Lee County Board Of County Commissioners **Blue Sheet No.** 20031262
Agenda Item Summary

1. REQUESTED MOTION:

ACTION REQUESTED: Approve Summary Plan Documents from Aetna Insurance. Remove Pre-certification and Step Therapy from the pharmacy program effective 1/1/04. Approve the Flexible Spending Account plan document. Adopt a time limit of December 31. 2003 for all the old claims from Florida 1st to be paid.

WHY ACTION IS NECESSARY: Benefits documents must be updated to reflect current regulations and practices.

WHAT ACTION ACCOMPLISHES: Allows us to update our current documents. Our Flexible Spending Account document will reflect the latest IRS rulings. This will recognize that Florida 1st will cease to pay claims on December 31, 2003.

2. DEPARTMENTAL CATEGORY: C6D
COMMISSION DISTRICT #
Countywide

3. MEETING DATE: 11-04-2003

4. AGENDA:
- x CONSENT
- ADMINISTRATIVE
- APPEALS
- PUBLIC
- WALK ON
- TIME REQUIRED:

5. REQUIREMENT/PURPOSE: *(Specify)*
- STATUTE
- ORDINANCE
- x ADMIN. CODE
- OTHER

6. REQUESTOR OF INFORMATION:
- A. COMMISSIONER
- B. DEPARTMENT Human Resources
- C. DIVISION
- BY: George A. Williams

7. BACKGROUND: Starting January 1, 2004, Aetna will be adding five new categories of drugs to the step therapy list. We do not feel that we should burden employees with need for additional pre-certification. The IRS has allowed over-the-counter drugs to be submitted for the Flexible Spending Accounts (where employees put away their own money pre-tax). Florida 1st will cease to pay claims after 12/31/03. This is full year after the last claims were received.

8. MANAGEMENT RECOMMENDATIONS:

9. RECOMMENDED APPROVAL:

A Department Director	B Purchasing or Contracts	C Human Resources	D Other	E County Attorney	F Budget Services				G County Manager
					Cafm 10/23/03				
George A. Williams 10/22/03		George A. Williams 10/22/03		Andrea Fraser	OA	OM 10/22/03	Risk 10/22/03	GC 10/21/03	

10. COMMISSION ACTION:
- APPROVED
- DENIED
- DEFERRED
- OTHER

RECEIVED BY COUNTY ADMIN: RF 10/22/03 1:20 pm SET
COUNTY ADMIN FORWARDED TO: DH 10/23

LEE COUNTY HEALTH ,DENTAL AND VISION BENEFIT PLANS

MEDICAL REIMBURSEMENT ACCOUNT
DEPENDENT CARE REIMBURSEMENT ACCOUNT
PRE-TAX PREMIUMS

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LEE COUNTY HEALTH AND DENTAL BENEFIT PLANS

INTRODUCTION

The Employer has amended this Plan effective January 1, 2004, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on January 1, 1990. The Plan shall be known as Lee County Health and Dental Benefit Plans Medical Reimbursement Account (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be includible or excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I
DEFINITIONS

1.1 "Administrator" means the individual(s) or corporation appointed by the Employer to carry out the administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Administrator.

1.2 "Affiliated Employer" means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 "Benefit" means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 "Cafeteria Plan Benefit Dollars" means the amount available to Participants, pursuant to Article III, to purchase Benefits. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 "Code" means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 "Compensation" means base compensation plus regularly scheduled over-time.

1.7 "Dependent" means any individual who qualifies as a dependent under an Insurance Contract or under Code Section 152 (as modified by Code Section 105(b)).

1.8 "Effective Date" means January 1, 1990.

1.9 "Election Period" means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 "Eligible Employee" means any Employee who has satisfied the provisions of Section 2.1.

1.11 "Employee" means any person who is employed by the Employer, but excludes any person who is employed as an independent contractor. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 "Employer" means Lee County Board of County Commissioners and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan.

1.13 "Insurance Contract" means any contract issued by an Insurer underwriting a Benefit.

1.14 "Insurer" means any insurance company that underwrites a Benefit under this Plan or, with respect to any self-funded benefits, the Employer.

1.15 "Key Employee" means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.16 "Participant" means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.17 "Plan" means this instrument, including all amendments thereto.

1.18 "Plan Year" means the 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.19 "Premium Expenses" or "Premiums" mean the Participant's cost for the self-funded Benefits described in Section 4.1.

1.20 "Premium Reimbursement Account" means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured or self-funded Benefit is elected, sub-accounts shall be established for each type of insured or self-funded Benefit.

1.21 "Salary Redirection" means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.22 "Salary Redirection Agreement" means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.23 "Spouse" means the legally married husband or wife of a Participant.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the date on which he satisfies the requirements of Section 2.1.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate and election of benefits form which the Administrator shall furnish to the Employee. The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to execute a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

(a) His termination of employment, subject to the provisions of Section 2.5;

(b) His death, subject to the provisions of Section 2.6; or

(c) The termination of this Plan, subject to the provisions of Section 10.2.

2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Plan shall be governed in accordance with the following:

(a) With regard to Insurance Benefits provided under Section 4.1, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

(b) With regard to the Dependent Care Assistance Program, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for the remainder of the Plan Year in which such termination occurs, based on the level of his Dependent Care Assistance Account as of his date of termination.

(c) With regard to the Health Care Reimbursement Plan, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for expenses incurred during the portion of the Plan Year preceding his date of termination.

(d) In the event a Participant terminates his participation in the Health Care Reimbursement Plan during the Plan Year, if Salary Redirections are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

(e) This Section shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 11.13 of the Plan.

2.6 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of his estate, may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Administrator may designate the Participant's Spouse, one of his Dependents or a representative of his estate.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Each Participant may elect to have his salary reduced pursuant to a Salary Redirection Agreement. Such Salary Redirection Agreement must be executed during the applicable Election Period. The amount of the Salary Redirection a Participant may elect for each Plan Year shall be up to $3,000. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Care Reimbursement Fund or Dependent Care Assistance Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Care Reimbursement Plan, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Redirections are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirections pursuant to Section 2.5.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect to have the amount of his Cafeteria Plan Benefit Dollars applied to any one or more of the following optional Benefits:

(1) Health Care Reimbursement Plan

(2) Dependent Care Assistance Program

(3) Benefit Payment Plan

- (i) Health Benefit
- (ii) Dental Benefit
- (iii) Vision Benefit

4.2 HEALTH CARE REIMBURSEMENT PLAN BENEFIT

Each Participant may elect coverage under the Health Care Reimbursement Plan option, in which case Article VI shall apply.

4.3 DEPENDENT CARE ASSISTANCE PROGRAM BENEFIT

Each Participant may elect coverage under the Dependent Care Assistance Program option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) Each Participant may elect to be covered under a health and hospitalization Contract for the Participant, his or her spouse, and his or her Dependents.

(b) The Employer may select suitable health and hospitalization Contracts for use in providing this health benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) The rights and conditions with respect to the benefits payable from such health and hospitalization Contract shall be determined therefrom, and such Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

(a) Each Participant may elect to be covered under the Employer's dental Contract. In addition, the Participant may elect either individual or family coverage under such Contract.

(b) The Employer may select suitable dental Contracts for use in providing this dental benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) The rights and conditions with respect to the benefits payable from such dental Contract shall be determined therefrom, and such dental Contract shall be incorporated herein by reference.

4.6 VISION INSURANCE BENEFIT

(a) Each Participant may elect to be covered under the Employer's vision Contract. In addition, the Participant may elect either individual or family coverage.

(b) The Employer may select suitable vision Contracts for use in providing this vision benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) The rights and conditions with respect to the benefits payable from such vision Contract shall be determined therefrom, and such vision Contract shall be incorporated herein by reference.

4.7 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any election or reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Care Reimbursement Plan Benefits and Dependent Care Assistance Program Benefits, and once all these Benefits are expended, proportionately among insured self-funded Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so before his effective date of participation pursuant to Section 2.2. However, if such Employee does not complete an application to participate and benefit election form and deliver it to the Administrator before such date, his Election Period shall extend 60 calendar days after such date, or for such further period as the Administrator shall determine and apply on a uniform and nondiscriminatory basis. However, any election during the extended 60-day election period pursuant to this Section 5.1 shall not be effective until the first pay period following the later of such Participant's effective date of participation pursuant to Section 2.2 or the date of the receipt of the election form by the Administrator, and shall be limited to the Benefit expenses incurred for the balance of the Plan Year for which the election is made.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which Benefit options he wishes to select and purchase with his Cafeteria Plan Benefit Dollars. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan.

5.3 FAILURE TO ELECT

Any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be treated in the following manner:

(a) With regard to Benefits available under the Plan for which no Premium Expenses apply, such Participant shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits.

(b) With regard to Benefits available under the Plan for which Premium Expenses apply, such Participant shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

5.4 CHANGE OF ELECTIONS

(a) Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce or annulment of marriage from a spouse, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, spouse or dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's spouse, or dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce or annulment.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations: The Plan Administrator must be notified of all changes within 60 days of the event.

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a spouse or annulment;

(2) Number of Dependents: Events that change a Participant's number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, spouse, or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, spouse, or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, spouse or dependent which changes the coverage.

For the Dependent Care Assistance Program, a dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

(b) Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f). Such change shall take place on a prospective basis.

(c) Notwithstanding subsection (a), in the event of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child (including a foster child who is a dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's spouse or dependent if the Participant or the Participant's spouse or dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's spouse or dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's spouse or dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a spouse's, former spouse's or dependent's employer if (1) the cafeteria plan or other benefits plan of the spouse's, former spouse's or dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a spouse's, former spouse's or dependent's employer.

A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Assistance Program only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

A Participant shall not be permitted to change an election to the Health Care Reimbursement Plan as a result of a cost or coverage change under this subsection.

ARTICLE VI
HEALTH CARE REIMBURSEMENT PLAN

6.1 ESTABLISHMENT OF PLAN

This Health Care Reimbursement Plan is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Care Reimbursement Plan may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed under this Health Care Reimbursement Plan shall be periodically paid from amounts allocated to the Health Care Reimbursement Fund. Periodic payments reimbursing Participants from the Health Care Reimbursement Fund shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) "Health Care Reimbursement Fund" means the fund established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses may be reimbursed.

(b) "Health Care Reimbursement Plan" means the plan of benefits contained in this Article, which provides for the reimbursement of eligible Medical Expenses incurred by a Participant or his Dependents.

(c) "Highly Compensated Participant" means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(d) "Medical Expenses" means any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213 and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. However, a Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's spouse or individual policies maintained by the Participant or his spouse or Dependent. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Plan.

6.3 FORFEITURES

The amount in the Health Care Reimbursement Fund as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Care Reimbursement Plan to the contrary, no more than $3,000 may be allocated to the Health Care Reimbursement Fund by a Participant in or on account of any Plan Year.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Health Care Reimbursement Plan not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) If the Administrator deems it necessary to avoid discrimination under this Health Care Reimbursement Plan, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Care Reimbursement Fund by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Care Reimbursement Fund for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Care Reimbursement Plan. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Care Reimbursement Plan. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH CARE REIMBURSEMENT PLAN CLAIMS

(a) All Medical Expenses incurred by a Participant shall be reimbursed during the Plan Year subject to Section 2.5, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Reimbursement Fund for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within the 90 day period immediately following the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

(d) Reimbursement payments under this Plan shall be made directly to the Participant.

(e) Claims Review Procedure. Within 180 days following receipt by the Participant of notice of the claim denial, or within 180 days following the close of the 60-day period referred to in Section 9.3 (c) if the Plan Administrator or its representative fails to notify the Participant of the decision during such time period, the Participant may appeal denial of the claim. The Participant shall be given an opportunity to review pertinent documents and to submit written comments, documents, records and other information relating to the claim for benefits. Following such request for review, the Plan Administrator or its representative shall fully and fairly review the decision denying the claim.

(f) Over-the-Counter medications as allowed under Section 213 of the IRS code must be submitted to the Plan Administrator with a receipt showing the name of the medication a the date purchased. A form must be submitted stating that this medication is for the employee for dependent. Cosmetics and toiletries are specifically excluded. In the case of items which may have a dual use, a doctor's note will be required.

ARTICLE VII
DEPENDENT CARE ASSISTANCE PROGRAM

7.1 ESTABLISHMENT OF PROGRAM

This Dependent Care Assistance Program is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed under this Dependent Care Assistance Program shall be paid from amounts allocated to the Participant's Dependent Care Assistance Account.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) "Dependent Care Assistance Account" means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed.

(b) "Dependent Care Assistance Program" means the program of benefits contained in this Article, which provides for the reimbursement of eligible expenses for the care of the Qualifying Dependents of Participants.

(c) "Earned Income" means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(d) "Employment-Related Dependent Care Expenses" means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(e)(1) (or deemed to be, as described in Section

7.2(e)(1) pursuant to Section 7.2(e)(3)), or for a Qualifying Dependent as defined in Section 7.2(e)(2) (or deemed to be, as described in Section 7.2(e)(2) pursuant to Section 7.2(e)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a dependent of such Participant or such Participant's Spouse.

(e) "Qualifying Dependent" means, for Dependent Care Assistance Program purposes,

(1) a Dependent of a Participant who is under the age of 13, with respect to whom the Participant is entitled to an exemption under Code Section 151(c);

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(f) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Assistance Program.

7.3 DEPENDENT CARE ASSISTANCE ACCOUNTS

The Administrator shall establish a Dependent Care Assistance Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Assistance Program benefits.

7.4 INCREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Assistance Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE ASSISTANCE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Assistance Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Assistance Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Assistance Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Dependent Care Assistance Program that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the

Dependent Care Assistance Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Assistance Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Assistance Program. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Assistance Program. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE ASSISTANCE PROGRAM CLAIMS

The Administrator shall direct the payment of all such Dependent Care Assistance claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) If a Participant fails to submit a claim within the 90 day period immediately following the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) Any claim for Benefits underwritten by Contracts shall be made to the Employer. If the Employer denies any claim, the Participant or beneficiary shall follow the Employer's claims review procedure. Any other claim for Benefits shall be made to the Administrator. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. If the Administrator does not notify the Participant of the denial of the claim within the 90 day period specified above, then the claim shall be deemed denied. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific references to the pertinent Plan provisions on which the denial is based;

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(3) an explanation of the Plan's claim procedure.

(b) Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

(1) request a review upon written notice to the Administrator;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

(c) A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(d) Any balance remaining in the Participants' Health Care Reimbursement Fund or Dependent Care Assistance Account as of the end of each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

(e) Notwithstanding the foregoing, in the case of a claim for medical expenses under the Health Care Reimbursement Plan, the following timetable for claims and rules below apply:

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under section 502 of ERISA following a denial on review.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the claim determination;

(2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will

be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall first be used to defray any administrative costs and experience losses and thereafter be retained by the Employer.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan;

(f) To approve reimbursement requests and to authorize the payment of benefits; and

(g) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.5 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 TERMINATION

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Contract shall be paid in accordance with the terms of the Contract.

No further additions shall be made to the Health Care Reimbursement Fund or Dependent Care Assistance Account, but all payments from such fund shall continue to be made according to the elections in effect until the end of the Plan Year in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims). Any amounts remaining in any such fund or account as of the end of the Plan Year in which Plan termination occurs shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.11.

11.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.7 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

11.8 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.9 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.10 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Florida.

11.11 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.12 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.13 CONTINUATION OF COVERAGE

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B.

11.14 FAMILY AND MEDICAL LEAVE ACT

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

11.15 DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER

(a) Definitions. Whenever used in this Section, the following terms shall have the respective meanings set for below.

(1) "Plan Administration Functions" shall mean administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.

(2) "Health Information" shall mean information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 CFR 160.103), employer, life insurer, school or university or health care clearinghouse (as defined in 45 CFR 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provisions of health care to an individual.

(3) "Individually Identifiable Health Information" shall mean Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.

(4) "Summary Health Information" shall mean information, including Individually Identifiable Health Information, that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed: (A) names; (B) geographic information more specific than state; (C) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the

year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older; (D) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN or serial numbers; (E) facial photographs or biometric identifiers (e.g., finger prints) and (F) any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.

(5) "Protected Health Information 'PHI')" shall mean Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

(b) Summary Health Information. The Plan may disclose Summary Heal Information to the Employer if the Employer requests such information for the purpose of modifying, amending, or terminating the Plan.

(c) Permitted Disclosures. The Plan will disclose PHI to the Employer only in accordance with 45 CFR 164.594(f) and the provisions of this Section. PHI disclosed to the Employer in accordance with this Section may only be used for the following permitted and required uses and disclosures;

- claims monitoring
- claims assistance
- claims auditing

(d) The Plan hereby incorporated the following provisions (1) through (10) to enable it to disclose PHI to the Employer and acknowledges receipt or written certification from the Employer that the Plan has been so amended. Additionally, the Employer agrees:

(1) not to use or further disclose PHI other than as permitted in this Section or as required by law;

(2) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;

(3) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;

(4) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in this paragraph;

(5) to make PHI available to individuals in accordance with 45 CFR 164.524;

(6) to make PHI available for individuals' amendment and incorporate any amendments in accordance with 45 CFR 164.526;

(7) to make the information available as required to provide individuals with an accounting of disclosures in accordance with 45 CFR 164.528;

(8) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request; and

(9) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction or the information infeasible,

(10) to ensure that adequate separation between the Plan and the Employer, as required by 45 CFR 164.504(f), is established and maintained.

(e) Disclosure to Employees. The Plan will disclose PHI only to the following employees or classes of employees:

- Director of Human Resources
- Manager of Human Resources
- their designees

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

(f) Noncompliance. Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section 11.15(e) shall be addressed in the following manner: The degree of noncompliance will be reviewed and remedial action will be taken which may include removing an offending employee from the select group with Access to PHI.

(g) A health insurance issuer or HMO providing services to the Plan is not permitted to disclose PHI to the Employer except as would be permitted by the Plan in this Section 11.15 and only if a notice is maintained and provided as required by 45 CFR 164.520.

11.16 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

IN WITNESS WHEREOF, this Plan document is hereby executed this _____ day of _____.

Lee County Board of County Commissioners

By _____
EMPLOYER

ADOPTING RESOLUTION

The undersigned Authorized Representative of Lee County Board of County Commissioners (the Employer) hereby certifies that the following resolutions were duly adopted by the Employer on _____, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of amended Cafeteria Plan including a Dependent Care Assistance Program and Health Care Reimbursement Plan effective January 1, 2003, presented to this meeting is hereby approved and adopted and that the duly authorized agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

RESOLVED, that the duly authorized agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Cafeteria Plan.

The undersigned further certifies that attached hereto as Exhibits A and B, respectively, are true copies of Lee County Health and Dental Benefit Plans as amended and restated and the Summary Plan Description approved and adopted in the foregoing resolutions.

_____
Authorized Representative

Date: _____

Summary of Coverage

Employer: Lee County Board of County Commissioners

ASA: 881673

SOC: 4B

Issue Date: January 6, 2003

Effective Date: January 1, 2003

The benefits shown in this Summary of Coverage are available dependents of covered employees of the above Employer.

Eligibility

You are in an Eligible Class if you are a dependant of a regular full-time employee and your are in an area in which there are Preferred Care Providers. Your Employer will provide you with this information.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the calendar month coinciding with or next following the date the employee completes a probationary period of one month of continuous service for the Employer or, if later, the date you enter the Eligible Class.

You may be covered if you are:

- the wife or husband of a covered employee; and
- the unmarried child of a covered employee, who is under 25 years of age.

Children include:

- biological children.
- adopted children.
- stepchildren.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Open Choice – Out-of-Area Dependants
Rural Networks

Enrollment Procedure

You will be required to enroll in a manner determined by Aetna and your Employer. This will allow your Employer to deduct your contributions from the employees pay. Be sure to enroll within 31 days of your Eligibility Date.

Contributions toward the cost of this coverage will be deducted from the employees pay and are subject to change. The rate of any required contributions will be determined by the Employer. See the Employer for details.

Effective Date of Coverage

Your coverage will take effect on the later to occur of:

- your Eligibility Date; and
- the date you return your signed form.

If you don't sign and return your form within 31 days of your Eligibility Date, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Coverage will take effect on the date the employees coverage takes effect if, by then, you have enrolled for dependent coverage. Any new dependents should be reported. This may affect contributions. If you do not do so within 31 days of any dependent's eligibility date, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Note: This Plan will pay a benefit for Covered Medical Expenses incurred by a newborn child during the first 31 days of life, whether or not the child is or becomes enrolled under the Plan.

If the child does not become enrolled under the Plan, coverage will terminate at the end of such 31 day period. Any Extension of Benefits provision will apply. The Continuation of Coverage under Federal Law provision will not apply.

Late Enrollee

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within 31 days of the date the person becomes eligible for such coverage.

Enrollment Procedure

You may elect coverage for a Late Enrollee only during the annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollee will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for the Late Enrollee.

Any preexisting condition limitation will apply to a Late Enrollee.

Exceptions

A person will not be considered to be a Late Enrollee if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:

  the person was covered under other "creditable coverage" as defined below; and

  you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
- the person loses such coverage because:

  of termination of employment in a class eligible for such coverage;

  of reduction in hours of employment;

  your spouse dies;

  you and your spouse divorce or are legally separated;

  such coverage was COBRA continuation and such continuation was exhausted; or

  the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

If you are not considered a Late Enrollee, Health Expense Coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A child who meets the definition of a dependent, but you elect it later in compliance with a court order requiring you to provide such coverage for your dependent child. Such coverage will become effective on the date specified by your Employer. Any limitation as to a preexisting condition may apply.
- A spouse, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.
- Yourself and your spouse and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Prescription Drug Expense Coverage

Payment Percentage
100% as to:

	Copay per Prescription or Refill	
	Supply of up to 30 days	Mail Order Drug Supply of over 30 days*
Preferred Pharmacy	$ 10	$ 10

* but no more than a 90 day maximum supply.

80% as to:

Non-Preferred Pharmacy	$ 10

A Separate Brand Name Fee may apply to a prescription for a brand name drug. See your Booklet for details.

Comprehensive Medical Expense Coverage

All maximums included in this Plan are combined maximums between Preferred Care and Non-Preferred Care, where applicable, unless specifically stated otherwise.

Certification Requirement

Certain types of care must be certified as necessary to avoid a reduction in the benefits payable. Read the Comprehensive Medical Expense Coverage section of the Booklet for details of the types of care affected, how to get certification and the effect on your benefits of failure to obtain certification.

Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Skilled Nursing Care.

Excluded Amount	$ 300

This Excluded Amount applies separately to each type of admission and care listed above.

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge." See your Employer for a copy of the Directory which lists these health care providers.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Deductible Amounts

Calendar Year Deductible	$ 300

This Calendar Year Deductible applies to all expenses except:

The following expenses incurred for Preferred Care:

- Fees of a physician for non-surgical office visits.
- Routine Mammogram Expenses

Inpatient Hospital Deductible:	
Preferred Care	$ 250
Non-Preferred Care	$ 500

However, for a confinement of a well newborn child that starts on the day of birth, this Inpatient Hospital Deductible will not exceed the hospital's actual charge for board and room for the first day of confinement on which the child's coverage is in force.

Payment Percentage

The Payment Percentage applies after any deductible amounts.

For Hospital Expenses*

Preferred Care	Non-Preferred Care	Other Health Care
90%	80%	80%

* Emergency Room Treatment (Emergency Care), as defined in your Booklet-Certificate, will be covered at the Preferred Care Rate.

For Physicians Fees

Preferred Care	Non-Preferred Care	Other Health Care
Non-surgical Office Visits - 100% after a $ 15 copay	80%	80%
Other - 90%	80%	80%

For Convalescent Facility, Home Health Care, Private Duty Nursing, Hospice Care, Short-Term Rehab, Diagnostic X-Ray and Lab, Durable Medical Equipment and Ambulance Expenses

Preferred Care	Non-Preferred Care	Other Health Care
80%	80%	80%

For Physical Exam Expenses

Refer to applicable category of "***Physician Fees***" above.

For Other Covered Medical Expenses

Covered Medical Expenses incurred for a routine mammogram

Preferred Care	100%
Non-Preferred Care	80%

For Other Covered Medical Expenses

100% as to:

National Medical Excellence Travel and Lodging Expenses

80%* as to:

All Other Medical Expenses for which a Payment Percentage is not otherwise shown.

* However, if the providers of services or supplies for which expenses are incurred are of a type that has contracted in sufficient numbers, as determined by Aetna, to furnish services or supplies for a Negotiated Charge, then the Payment Percentage will be the applicable Preferred Care or Non-Preferred Care Payment Percentage as specified above for Hospital Expenses. Such types of providers may include, but are not limited to:

To be sure that you will receive the full benefit available under this Plan, you should verify the provider's status by calling either the provider or the toll-free number shown on your ID card.

Reduced Payment Percentage

50% as to:

Non-emergency care in an emergency room.

Payment Percentage and Special Maximums for Alcoholism, Drug Abuse and Mental Disorders

	Preferred Care	Non-Preferred Care	Other Health Care
Alcoholism and Drug Abuse			
Inpatient Treatment	90%	80%	80%
Outpatient Treatment	80%	50%	80%
Special Inpatient Calendar Year Maximum Days	30		
Special Outpatient Calendar Year Maximum Visits	20		
Mental Disorders			
Inpatient Treatment	90%	80%	80%
Outpatient Treatment	100% after a $15 copay	80%	80%

Payment Limits

These limits apply only to Covered Medical Expenses which are payable at a rate greater than 50% and not applied against any deductible or copay amount.

It does not apply to expenses incurred for the effective treatment of alcoholism and drug abuse and for the treatment of mental disorders while not confined as a full-time inpatient.

Payment Limit which Applies to Expenses for a Person

When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach $ 2,000 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches $ 4,000, then benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

Benefit Maximums

(Read the coverage section in your Booklet for a complete description of the benefits available.)

Convalescent Days	60 per calendar year
Home Health Care Maximum Visits	120 per calendar year
Hospice Care	
Maximum Number of Days	30
Outpatient Maximum	$ 5,000
Private Duty Nursing Care	
Maximum Shifts	70 per calendar year
National Medical Excellence	
Lodging Expenses Maximum	$ 50.00
Travel and Lodging Maximum	$ 10,000
Private Room Limit	The institution's semiprivate rate.

Lifetime Maximum Benefit: There is no Lifetime Maximum Benefit (overall limit) that applies to the Comprehensive Medical benefits described in the Booklet. The only maximum benefit limits are those specifically mentioned in your Booklet.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.

- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer. Any increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

"If your employer has arranged for services to be performed by a provider network or providers in a geographic area where Aetna does not have a network of contracted providers, the following apply with respect to those non-Aetna providers:

1. Member understands that neither Aetna Life Insurance Company nor any of its affiliates ("Aetna") credentials, monitors or oversees the non-Aetna providers or any of the administrative procedures or practices of the non-Aetna provider network; that no discounts may in fact be provided or made available by any particular provider within the non-Aetna provider network, and that providers in the non-Aetna provider network may not necessarily be available, accessible or convenient. Member further understands that providers in the non-Aetna provider network are providers in private practice, have no agreements with Aetna or any of its affiliates, are neither agents nor employees of Aetna or its affiliated companies, and are solely responsible for the health care services that they deliver.

2. Member understands that if Aetna or an affiliated company contracts with providers to provide services in the geographic area being serviced by the non-Aetna providers, Aetna may terminate the arrangement with the non-Aetna provider network and that such conversion may cause disruption, including the possibility that a particular provider in the non-Aetna provider network may not be included in the Aetna network of contracted providers."

KEEP THIS SUMMARY OF COVERAGE WITH YOUR BOOKLET

Additional Information Provided by
Lee County Board of County Commissioners

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, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) 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 subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

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

Summary of Coverage

Employer: Lee County Board of County Commissioners

ASA: 881673

SOC: 4A

Issue Date: January 6, 2003

Effective Date: January 1, 2003

The benefits shown in this Summary of Coverage are available dependents of covered employees of the above Employer.

Eligibility

You are in an Eligible Class if you are a dependant of a regular full-time employee and your are in an area in which there are Preferred Care Providers. Your Employer will provide you with this information.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the calendar month coinciding with or next following the date the employee completes a probationary period of one month of continuous service for the Employer or, if later, the date you enter the Eligible Class.

You may be covered if you are:

- the wife or husband of a covered employee; and
- the unmarried child of a covered employee, who is under 25 years of age.

Children include:

- biological children.
- adopted children.
- stepchildren.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

You will be required to enroll in a manner determined by Aetna and your Employer. This will allow your Employer to deduct your contributions from the employees pay. Be sure to enroll within 31 days of your Eligibility Date.

Contributions toward the cost of this coverage will be deducted from the employees pay and are subject to change. The rate of any required contributions will be determined by the Employer. See the Employer for details.

Effective Date of Coverage

Your coverage will take effect on the later to occur of:

- your Eligibility Date; and
- the date you return your signed form.

If you don't sign and return your form within 31 days of your Eligibility Date, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Coverage will take effect on the date the employees coverage takes effect if, by then, you have enrolled for dependent coverage. Any new dependents should be reported. This may affect contributions. If you do not do so within 31 days of any dependent's eligibility date, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Note: This Plan will pay a benefit for Covered Medical Expenses incurred by a newborn child during the first 31 days of life, whether or not the child is or becomes enrolled under the Plan.

If the child does not become enrolled under the Plan, coverage will terminate at the end of such 31 day period. Any Extension of Benefits provision will apply. The Continuation of Coverage under Federal Law provision will not apply.

Late Enrollee

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within 31 days of the date the person becomes eligible for such coverage.

Enrollment Procedure

You may elect coverage for a Late Enrollee only during the annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollee will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for the Late Enrollee.

Any preexisting condition limitation will apply to a Late Enrollee.

Exceptions

A person will not be considered to be a Late Enrollee if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:

  the person was covered under other "creditable coverage" as defined below; and

  you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
- the person loses such coverage because:

  of termination of employment in a class eligible for such coverage;

  of reduction in hours of employment;

  your spouse dies;

  you and your spouse divorce or are legally separated;

  such coverage was COBRA continuation and such continuation was exhausted; or

  the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

If you are not considered a Late Enrollee, Health Expense Coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A child who meets the definition of a dependent, but you elect it later in compliance with a court order requiring you to provide such coverage for your dependent child. Such coverage will become effective on the date specified by your Employer. Any limitation as to a preexisting condition may apply.
- A spouse, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.
- Yourself and your spouse and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Prescription Drug Expense Coverage

Payment Percentage

100% as to:

	Copay per Prescription or Refill	
	Supply of up to 30 days	Mail Order Drug Supply of over 30 days*
Preferred Pharmacy	$ 10	$ 10

* but no more than a 90 day maximum supply.

80% as to:

Non-Preferred Pharmacy	$ 10

A Separate Brand Name Fee may apply to a prescription for a brand name drug. See your Booklet for details.

Comprehensive Medical Expense Coverage

All maximums included in this Plan are combined maximums between Preferred Care and Non-Preferred Care, where applicable, unless specifically stated otherwise.

Certification Requirement

Certain types of care must be certified as necessary to avoid a reduction in the benefits payable. Read the Comprehensive Medical Expense Coverage section of the Booklet for details of the types of care affected, how to get certification and the effect on your benefits of failure to obtain certification.

Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Skilled Nursing Care.

Excluded Amount	$ 300

This Excluded Amount applies separately to each type of admission and care listed above.

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge." See your Employer for a copy of the Directory which lists these health care providers.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Deductible Amounts

Calendar Year Deductible	$ 300

This Calendar Year Deductible applies to all expenses except:

The following expenses incurred for Preferred Care:

- Fees of a physician for non-surgical office visits.
- Routine Mammogram Expenses

Inpatient Hospital Deductible:	
Preferred Care	$ 250
Non-Preferred Care	$ 500

However, for a confinement of a well newborn child that starts on the day of birth, this Inpatient Hospital Deductible will not exceed the hospital's actual charge for board and room for the first day of confinement on which the child's coverage is in force.

Payment Percentage

The Payment Percentage applies after any deductible amounts.

For Hospital Expenses*

Preferred Care	Non-Preferred Care	Other Health Care
90%	80%	80%

* Emergency Room Treatment (Emergency Care), as defined in your Booklet-Certificate, will be covered at the Preferred Care Rate.

For Physicians Fees

Preferred Care	Non-Preferred Care	Other Health Care
Non-surgical Office Visits - 100% after a $ 15 copay	80%	80%
Other - 90%	80%	80%

For Convalescent Facility, Home Health Care, Private Duty Nursing, Hospice Care, Short-Term Rehab, Diagnostic X-Ray and Lab, Durable Medical Equipment and Ambulance Expenses

Preferred Care	Non-Preferred Care	Other Health Care
80%	80%	80%

For Physical Exam Expenses

Refer to applicable category of "***Physician Fees***" above.

For Other Covered Medical Expenses

Covered Medical Expenses incurred for a routine mammogram

Preferred Care	100%
Non-Preferred Care	80%

For Other Covered Medical Expenses

100% as to:

National Medical Excellence Travel and Lodging Expenses

80%* as to:

All Other Medical Expenses for which a Payment Percentage is not otherwise shown.

* However, if the providers of services or supplies for which expenses are incurred are of a type that has contracted in sufficient numbers, as determined by Aetna, to furnish services or supplies for a Negotiated Charge, then the Payment Percentage will be the applicable Preferred Care or Non-Preferred Care Payment Percentage as specified above for Hospital Expenses. Such types of providers may include, but are not limited to:

To be sure that you will receive the full benefit available under this Plan, you should verify the provider's status by calling either the provider or the toll-free number shown on your ID card.

Reduced Payment Percentage

50% as to:

Non-emergency care in an emergency room.

Payment Percentage and Special Maximums for Alcoholism, Drug Abuse and Mental Disorders

	Preferred Care	Non-Preferred Care	Other Health Care
Alcoholism and Drug Abuse			
Inpatient Treatment	90%	80%	80%
Outpatient Treatment	80%	50%	80%
Special Inpatient Calendar Year Maximum Days	30		
Special Outpatient Calendar Year Maximum Visits	20		
Mental Disorders			
Inpatient Treatment	90%	80%	80%
Outpatient Treatment	100% after a $15 copay	80%	80%

Payment Limits

These limits apply only to Covered Medical Expenses which are payable at a rate greater than 50% and not applied against any deductible or copay amount.

It does not apply to expenses incurred for the effective treatment of alcoholism and drug abuse and for the treatment of mental disorders while not confined as a full-time inpatient.

Payment Limit which Applies to Expenses for a Person

When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach $ 2,000 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches $ 4,000, then benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

Benefit Maximums

(Read the coverage section in your Booklet for a complete description of the benefits available.)

Convalescent Days	60 per calendar year
Home Health Care Maximum Visits	120 per calendar year
Hospice Care	
Maximum Number of Days	30
Outpatient Maximum	$ 5,000
Private Duty Nursing Care	
Maximum Shifts	70 per calendar year
National Medical Excellence	
Lodging Expenses Maximum	$ 50.00
Travel and Lodging Maximum	$ 10,000
Private Room Limit	The institution's semiprivate rate.

Lifetime Maximum Benefit: There is no Lifetime Maximum Benefit (overall limit) that applies to the Comprehensive Medical benefits described in the Booklet. The only maximum benefit limits are those specifically mentioned in your Booklet.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.

- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer. Any increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

KEEP THIS SUMMARY OF COVERAGE WITH YOUR BOOKLET

Additional Information Provided by
Lee County Board of County Commissioners

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, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) 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 subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

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

Summary of Coverage

Employer: Lee County Board of County Commissioners

ASA: 881673

SOC: 3A

Issue Date: January 6, 2003

Effective Date: January 1, 2003

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

Eligibility

Employees

You are in an Eligible Class if you are a regular full-time employee of an Employer participatient in this Plan.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the calendar year coinciding with or next following the date you complete a probationary period of one month of continuous service for your Employer or, if later, the date you enter the Eligible Class.

You can remain in an Eligible Class as a retired employee if you retire under your Employer's IRS Qualified Retirement Plan and will receive a pension, except a deferred vested pension. You may continue your Health Expense Coverage and any coverage you have for your dependents.

If you retired before the Effective Date of this Plan, you are also in an Eligible Class. You must follow the Enrollment Procedure. You may have Health Expense Coverage for you and your dependents.

Dependents

When you join the Plan, your spouse and your dependent children are also eligible to join. A dependent child must be unmarried and under the age of 25. Coverage will continue until end of the year in which the child attains age 25.

You may enroll your natural child, foster child, stepchild, legally adopted child, or a child or grandchild in your court-ordered custody.

Dependents eligible to participate include a lawful spouse, and unmarried children, up to the last day of the calendar year in which they attain age 25 if a full-time/part-time student at an accredited school, college, or university, and dependent upon the employee for support; or, residing in the household of the employee, and dependent upon the employee for support; each unmarried, natural, adopted- from-moment-of-placement in the home, step or foster child, and children under court-appointed legal guardianship, who are either: (a) a full-time or part-time student at an accredited school, college, or university, and dependent upon the employee for support; or, (b) residing in the household of the employee and dependent upon the employee for support.

The newborn child of a covered dependent child is eligible for benefits for up to 18 months of age as long as the parent continues to be a dependent.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

You will get a form to fill out. This form will allow your Employer to deduct your contributions for dependents coverage from your pay. Be sure to sign and return it within 31 days of your eligibility.

Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details. If you are eligible for any coverage as a retired employee, your Employer will advise you concerning the method and amount of any required contributions.

Effective Date of Coverage

Employees

Your coverage will take effect on your Eligibility Date.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions.

Note: This Plan will pay a benefit for Covered Medical Expenses incurred by a newborn child during the first 31 days of life, whether or not the child is or becomes enrolled under the Plan.

If the child does not become enrolled under the Plan, coverage will terminate at the end of such 31 day period. Any Extension of Benefits provision will apply. The Continuation of Coverage under Federal Law provision will not apply.

Retired Employees

In lieu of corresponding rules which apply to employees:

- If any Health Expense Benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when Health Expense Coverage terminates will also apply to you.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

Comprehensive Dental Expense Coverage

Calendar Year Deductible	$ 50
The Calendar Year Deductible applies to all expenses except Type A Expenses.	
Family Deductible Limit	$ 100

After the deductible, the dental expense benefits payable under this plan in a calendar year are paid at the payment percentage below. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide dental services or supplies at a negotiated charge. See your Employer for a copy of the Directory which lists these health care providers.

Payment Percentage	
Type A Expenses	100%
Type B Expenses	80%
Type C Expenses	50%
Orthodontic Treatment	50%
Calendar Year Maximum	$ 1,000
Orthodontic Lifetime Maximum	$ 1,000

Summary of Coverage

Employer: Lee County Board of County Commissioners

ASA: 881673

SOC: 2A

Issue Date: January 6, 2003

Effective Date: January 1, 2003

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

Eligibility

Employees

You are in an Eligible Class if you are a regular full-time employee of an Employer participating in this Plan.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the calendar month coinciding with or next following the date you complete a probationary period of one month of continuous service for your Employer or, if later, the date you enter the Eligible Class.

You can remain in an Eligible Class as a retired employee if you retire under your Employer's IRS Qualified Retirement Plan and will receive a pension, except a deferred vested pension. You may continue your Health Expense Coverage and any coverage you have for your dependents.

If you retired before the Effective Date of this Plan, you are also in an Eligible Class. You must follow the Enrollment Procedure. You may have Health Expense Coverage for you and your dependents.

Dependents

When you join the Plan, your spouse and your dependent children are also eligible to join. A dependent child must be unmarried and under the age of 25. Coverage will continue until end of the year in which the child attains age 25.

You may enroll your natural child, foster child, stepchild, legally adopted child, or a child or grandchild in your court-ordered custody.

Dependents eligible to participate include a lawful spouse, and unmarried children, up to the last day of the calendar year in which they attain age 25 if a full-time/part-time student at an accredited school, college, or university, and dependent upon the employee for support; or, residing in the household of the employee, and dependent upon the employee for support; each unmarried, natural, adopted- from-moment-of-placement in the home, step or foster child, and children under court-appointed legal guardianship, who are either: (a) a full-time or part-time student at an accredited school, college, or university, and dependent upon the employee for support; or, (b) residing in the household of the employee and dependent upon the employee for support.

The newborn child of a covered dependent child is eligible for benefits for up to 18 months of age as long as the parent continues to be a dependent.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

You will get a form to fill out. This form will allow your Employer to deduct your contributions for dependents coverage from your pay. Be sure to sign and return it within 31 days of your eligibility.

Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details. If you are eligible for any coverage as a retired employee, your Employer will advise you concerning the method and amount of any required contributions.

Effective Date of Coverage

Employees

Your coverage will take effect on your Eligibility Date.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions. If you do not do so within 31 days of any dependent's eligibility date, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Note: This Plan will pay a benefit for Covered Medical Expenses incurred by a newborn child during the first 31 days of life, whether or not the child is or becomes enrolled under the Plan.

If the child does not become enrolled under the Plan, coverage will terminate at the end of such 31 day period. Any Extension of Benefits provision will apply. The Continuation of Coverage under Federal Law provision will not apply.

Late Enrollee

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within 31 days of the date the person becomes eligible for such coverage.

Enrollment Procedure

You may elect coverage for a Late Enrollee only during the annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollee will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for the Late Enrollee.

Any preexisting condition limitation will apply to a Late Enrollee.

Exceptions

A person will not be considered to be a Late Enrollee if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:

  the person was covered under other "creditable coverage" as defined below; and

  you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
- the person loses such coverage because:

  of termination of employment in a class eligible for such coverage;

  of reduction in hours of employment;

  your spouse dies;

  you and your spouse divorce or are legally separated;

  such coverage was COBRA continuation and such continuation was exhausted; or

  the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

If you are not considered a Late Enrollee, Health Expense Coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A child who meets the definition of a dependent, but you elect it later in compliance with a court order requiring you to provide such coverage for your dependent child. Such coverage will become effective on the date specified by your Employer. Any limitation as to a preexisting condition may apply.
- A spouse, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.
- Yourself and your spouse and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Retired Employees

In lieu of corresponding rules which apply to employees:

- If any Health Expense Benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when Health Expense Coverage terminates will also apply to you.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Prescription Drug Expense Coverage

Payment Percentage

100% as to:

Preferred Pharmacy	Copay per Prescription or Refill	
	Supply of up to 30 days	Mail Order Drug Supply of over 30 days*
Generic Drugs	$ 10	$ 10
Brand Name Drugs		
On Medication Formulary	$ 20	$ 20
Not on Medication Formulary	$ 35	$ 35

70% as to:

Non-Preferred Pharmacy	
Generic Drugs	$ 10
Brand Name Drugs	
On Medication Formulary	$ 20
Not on Medication Formulary	$ 35

* but no more than a 90 day maximum supply.

Comprehensive Medical Expense Coverage

Certification Requirement

If you or one of your dependents require confinement in a hospital:

Days in the hospital must be certified if full plan benefits are to be available.

As soon as you or one of your dependents know confinement will be required, read the Comprehensive Medical Expense Coverage section of the Booklet for details on how to get the certification.

Certification for Hospital Admissions Excluded Amount	$ 500

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet.

Deductible Amounts

Calendar Year Deductible	$ 300

The Calendar Year Deductible applies to all expenses except:

Hospice Care Expenses.
Covered Medical Expenses incurred in connection with a Routine Physical Exam, including Well Child and Immunization Expenses.
Covered Medical Expenses incurred in connection with a Routine Mammogram.
Prostate Specific Antigen Test, and Digital Rectal Exam Expenses.
Covered Medical Expenses incurred in connection with a Routine gynecological exam, included Pap Smear and related fees.
Expenses incurred as part of the Healthy Outlook Program.

Family Deductible Limit	$ 600
Inpatient Hospital Deductible	$ 250

However, for a confinement of a well newborn child that starts on the day of birth, this Inpatient Hospital Deductible will not exceed the hospital's actual charge for board and room for the first day of confinement on which the child's coverage is in force.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Payment Percentage

For Other Covered Medical Expenses
100% as to:

National Medical Excellence Travel and Lodging Expenses
Hospice Care Expenses
Expenses incurred in connection with a Routine Physical Exam
Expenses incurred in connection with a Routine Mammogram
Expenses authorized under the Healthy Outlook Program

For Routine Eye Exam Expenses
100% after the Calendar Year Deductible

For Routine Hearing Exam Expenses
100% after the Calendar Year Deductible

80% in excess of each Inpatient Hospital Deductible as to:

Inpatient Hospital Expenses

80% as to:

Outpatient Hospital Expenses (as defined)
Convalescent Facility Expenses
Home Health Care Expenses
Other Medical Expenses for which a Payment Percentage is not otherwise shown

Reduced Payment Percentage

50% as to:

Non-emergency care in an emergency room.

Payment Percentage and Special Maximums for Alcoholism, Drug Abuse and Mental Disorders

Alcoholism, Drug Abuse, and Mental Disorders

Outpatient Treatment	
Payment Percentage	80%
Special Inpatient Calendar	
Year Maximum Days	30*
Special Outpatient Calendar	
Year Maximum Visits	45*

*Inpatient Days and Outpatient Visits for Alcoholism, Drug Abuse and Mental Disorders are Combined Maximums.

Payment Limits

These limits apply only to Covered Medical Expenses which are payable at a rate greater than 50% and not applied against any deductible.

It does not apply to expenses incurred for the effective treatment of alcoholism and drug abuse and for the treatment of mental disorders while not confined as a full-time inpatient.

Payment Limit which Applies to Expenses for a Person

When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach $ 1,000 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Payment Limit which Applies to Expenses for a Family

When a family's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach $ 2,000 in a calendar year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Benefit Maximums

(Read the coverage section in your Booklet for a complete description of the benefits available.)

Convalescent Days	90 per calendar year
Home Health Care Maximum Visits	120 per calendar year
Private Duty Nursing Care Maximum Shifts	70 per calendar year
National Medical Excellence	
Lodging Expenses Maximum	$ 50
Travel and Lodging Maximum	$ 10,000
Private Room Limit	The institution's semiprivate rate.

Lifetime Maximum Benefit: There is no Lifetime Maximum Benefit (overall limit) that applies to the Comprehensive Medical benefits described in the Booklet. The only maximum benefit limits are those specifically mentioned in your Booklet.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.

- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.
Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer. Any increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

KEEP THIS SUMMARY OF COVERAGE WITH YOUR BOOKLET

Additional Information Provided by
Lee County Board of County Commissioners

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, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) 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 subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

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

Summary of Coverage

Employer: Lee County Board of County Commissioners

ASA: 881673

SOC: 1B

Issue Date: January 6, 2003

Effective Date: January 1, 2003

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

Eligibility

Employees

You are in an Eligible Class if you are a regular full-time employee and your are in an area in which there are Preferred Care Providers. Your Employer will provide you with this information.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the month coinciding with or next following the date you complete a probationary period of one month of continuous service for your Employer or, if later, the date you enter the Eligible Class.

You can remain in an Eligible Class as a retired employee if you retire under your Employer's IRS Qualified Retirement Plan and will receive a pension, except a deferred vested pension. You may continue your Health Expense Coverage and any coverage you have for your dependents.

If you retired before the Effective Date of this Plan, you are also in an Eligible Class. You must follow the Enrollment Procedure. You may have Health Expense Coverage for you and your dependents.

Dependents

When you join the Plan, your spouse and your dependent children are also eligible to join. A dependent child must be unmarried and under the age of 25. Coverage will continue until end of the year in which the child attains age 25.

You may enroll your natural child, foster child, stepchild, legally adopted child, or a child or grandchild in your court-ordered custody.

Dependents eligible to participate include a lawful spouse, and unmarried children, up to the last day of the calendar year in which they attain age 25 if a full-time/part-time student at an accredited school, college, or university, and dependent upon the employee for support; or, residing in the household of the employee, and dependent upon the employee for support; each unmarried, natural, adopted- from-moment-of-placement in the home, step or foster child, and children under court-appointed legal guardianship, who are either: (a) a full-time or part-time student at an accredited school, college, or university, and dependent upon the employee for support; or, (b) residing in the household of the employee and dependent upon the employee for support.

The newborn child of a covered dependent child is eligible for benefits for up to 18 months of age as long as the parent continues to be a dependent.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

You will get a form to fill out. This form will allow your Employer to deduct your contributions for dependents coverage from your pay. Be sure to sign and return it within 31 days of your eligibility.

Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details. If you are eligible for any coverage as a retired employee, your Employer will advise you concerning the method and amount of any required contributions.

Effective Date of Coverage

Employees

Your coverage will take effect on your Eligibility Date.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions. If you do not do so within 31 days of any dependent's eligibility date, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Note: This Plan will pay a benefit for Covered Medical Expenses incurred by a newborn child during the first 31 days of life, whether or not the child is or becomes enrolled under the Plan.

If the child does not become enrolled under the Plan, coverage will terminate at the end of such 31 day period. Any Extension of Benefits provision will apply. The Continuation of Coverage under Federal Law provision will not apply.

Late Enrollee

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within 31 days of the date the person becomes eligible for such coverage.

Enrollment Procedure

You may elect coverage for a Late Enrollee only during the annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollee will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for the Late Enrollee.

Any preexisting condition limitation will apply to a Late Enrollee.

Exceptions

A person will not be considered to be a Late Enrollee if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:

  the person was covered under other "creditable coverage" as defined below; and

  you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
- the person loses such coverage because:

  of termination of employment in a class eligible for such coverage;

  of reduction in hours of employment;

  your spouse dies;

  you and your spouse divorce or are legally separated;

  such coverage was COBRA continuation and such continuation was exhausted; or

  the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

If you are not considered a Late Enrollee, Health Expense Coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A child who meets the definition of a dependent, but you elect it later in compliance with a court order requiring you to provide such coverage for your dependent child. Such coverage will become effective on the date specified by your Employer. Any limitation as to a preexisting condition may apply.
- A spouse, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.
- Yourself and your spouse and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Retired Employees

In lieu of corresponding rules which apply to employees:

- If any Health Expense Benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when Health Expense Coverage terminates will also apply to you.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Prescription Drug Expense Coverage

Payment Percentage

100% as to:

Preferred Pharmacy	Copay per Prescription or Refill	
	Supply of up to 30 days	Mail Order Drug Supply of over 30 days*
Generic Drugs	$ 10	$ 10
Brand Name Drugs		
On Medication Formulary	$ 20	$ 20
Not on Medication Formulary	$ 35	$ 35

70% as to:

Non-Preferred Pharmacy	
Generic Drugs	$ 10
Brand Name Drugs	
On Medication Formulary	$ 20
Not on Medication Formulary	$ 35

* but no more than a 90 day maximum supply.

Comprehensive Medical Expense Coverage

All maximums included in this Plan are combined maximums between Preferred Care and Non-Preferred Care, where applicable, unless specifically stated otherwise.

Certification Requirement

Certain types of care must be certified as necessary to avoid a reduction in the benefits payable. Read the Comprehensive Medical Expense Coverage section of the Booklet for details of the types of care affected, how to get certification and the effect on your benefits of failure to obtain certification.

Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Skilled Nursing Care.
Excluded Amount $ 500

This Excluded Amount applies separately to each type of admission and care listed above.

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge." See your Employer for a copy of the Directory which lists these health care providers.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Deductible Amounts

Calendar Year Deductible $ 500

When Covered Medical Expenses applied against a person's Calendar Year Deductible in any calendar year equal $ 300, the Calendar Year Deductible will not apply to preferred care or other health care during the rest of that calendar year. Covered Medical Expenses incurred during the rest of that calendar year for preferred care and other health care will not be applied against the person's Calendar Year Deductible.

This Calendar Year Deductible applies to all expenses except:

The following expenses incurred for Non-Preferred Care:

- Hospice Care Expenses
- Emergency use of an Emergency Room
- Expenses incurred as part of the Healthy Outlook Program

The following expenses incurred for Preferred Care:

- Fees of a physician for non-surgical office visits.
- Routine Physical Exam Expenses
- Covered Medical Expenses incurred in connection with Mammograms
- Covered Medical Expenses incurred in connection with Pap Smears

Family Deductible Limit $ 1,000

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal $ 600, the Calendar Year Deductible will not apply to expenses incurred for preferred and other health care during the rest of that calendar year for you and your dependents.

Inpatient Hospital Deductible $ 250

However, for a confinement of a well newborn child that starts on the day of birth, this Inpatient Hospital Deductible will not exceed the hospital's actual charge for board and room for the first day of confinement on which the child's coverage is in force.

This Inpatient Hospital Deductible applies to all Inpatient Hospital Expenses, except those incurred for Preferred Care.

Emergency Room Deductible $ 75 per visit

This Emergency Room Deductible applies to Hospital Expenses incurred for emergency care provided by a Non-Preferred Care Provider. This amount is waived if the person becomes confined in a hospital.

Emergency Room Copay $ 75 per visit

This Emergency Room Copay applies to Hospital Expenses incurred for emergency care provided by a Preferred Care Provider. This amount is waived if the person becomes confined in a hospital.

Payment Percentage

The Payment Percentage applies after any deductible amounts.

For Hospital Expenses

Preferred Care	Non-Preferred Care	Other Health Care
90%	70%	80%

For Physicians Fees

Preferred Care	Non-Preferred Care	Other Health Care
Non-surgical Office Visits - 100% after a $ 10 copay	70%	80%
Other - 90%	70%	80%

For Covered Mammogram Expenses

Preferred Care	Non-Preferred Care	Other Health Care
100%	70%	80%

Physicians Fees for Routine Eye Exam Expenses

Preferred Care	Non-Preferred Care	Other Health Care
Non-surgical Office Visits - 100% after a $ 25 copay	70%	80%
Other - 90%	70%	80%

Physicians Fees for Routine Hearing Exams

Preferred Care	Non-Preferred Care	Other Health Care
Non-surgical Office Visits - 100% after a $ 25 copay	70%	80%
Other - 90%	70%	80%

For Physical Exam Expenses
Refer to applicable category of "***Physician Fees***" above.

For Hospice Care Expenses
The Calendar Year Deductible will be waived for Inpatient Hospice Coverage and Outpatient Hospice Coverage and considered at 100% for Preferred Care and Non-Preferred Care.

For Other Covered Medical Expenses
100% as to:

National Medical Excellence Travel and Lodging Expenses
Expenses authorized under the Healthy Outlook Program
Hospice Care Expenses

80%* as to:

Convalescent Facility Expenses
Home Health Care Expenses
All Other Medical Expenses for which a Payment Percentage is not otherwise shown.

* However, if the providers of services or supplies for which expenses are incurred are of a type that has contracted in sufficient numbers, as determined by Aetna, to furnish services or supplies for a Negotiated Charge, then the Payment Percentage will be the applicable Preferred Care or Non-Preferred Care Payment Percentage as specified above for Hospital Expenses. Such types of providers may include, but are not limited to:

Home Health Care agencies;
Diagnostic laboratories;
Durable Medical Equipment suppliers;
Ambulance services.

To be sure that you will receive the full benefit available under this Plan, you should verify the provider's status by calling either the provider or the toll-free number shown on your ID card.

Reduced Payment Percentage

50% as to:

Non-emergency care in an emergency room.

Payment Percentage and Special Maximums for Alcoholism, Drug Abuse and Mental Disorders

	Preferred Care	Non-Preferred Care	Other Health Care
Alcoholism, Drug Abuse, and Mental Disorders			
Inpatient Treatment	90%	70%	80%
Outpatient Treatment	90%	70%	80%
Special Inpatient Calendar Year Maximum Days	30*		
Special Outpatient Calendar Year Maximum Visits	45*		

*Preferred and Non-Preferred Inpatient Days and Outpatient Visits for Alcoholism, Drug Abuse and Mental Disorders are Combined Maximums.

Payment Limits

These limits apply only to Covered Medical Expenses which are payable at a rate greater than 50% and not applied against any deductible or copay amount.

Payment Limit which Applies to Expenses for a Person

When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach $ 1,000 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches $ 2,000, then benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

Payment Limit which Applies to Expenses for a Family

When a family's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach $ 2,000 in a calendar year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches $ 4,000, then benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

Benefit Maximums

(Read the coverage section in your Booklet for a complete description of the benefits available.)

Convalescent Days	90 per calendar year
Home Health Care Maximum Visits	120 per calendar year
Private Duty Nursing Care Maximum Shifts	70 per calendar year
National Medical Excellence	
Lodging Expenses Maximum	$ 50.00
Travel and Lodging Maximum	$ 10,000
Private Room Limit	The institution's semiprivate rate.

Lifetime Maximum Benefit: There is no Lifetime Maximum Benefit (overall limit) that applies to the Comprehensive Medical benefits described in the Booklet. The only maximum benefit limits are those specifically mentioned in your Booklet.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.

- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer. Any increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

"If your employer has arranged for services to be performed by a provider network or providers in a geographic area where Aetna does not have a network of contracted providers, the following apply with respect to those non-Aetna providers:

1. Member understands that neither Aetna Life Insurance Company nor any of its affiliates ("Aetna") credentials, monitors or oversees the non-Aetna providers or any of the administrative procedures or practices of the non-Aetna provider network; that no discounts may in fact be provided or made available by any particular provider within the non-Aetna provider network, and that providers in the non-Aetna provider network may not necessarily be available, accessible or convenient. Member further understands that providers in the non-Aetna provider network are providers in private practice, have no agreements with Aetna or any of its affiliates, are neither agents nor employees of Aetna or its affiliated companies, and are solely responsible for the health care services that they deliver.

2. Member understands that if Aetna or an affiliated company contracts with providers to provide services in the geographic area being serviced by the non-Aetna providers, Aetna may terminate the arrangement with the non-Aetna provider network and that such conversion may cause disruption, including the possibility that a particular provider in the non-Aetna provider network may not be included in the Aetna network of contracted providers."

KEEP THIS SUMMARY OF COVERAGE WITH YOUR BOOKLET

Additional Information Provided by
Lee County Board of County Commissioners

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, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) 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 subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

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

Summary of Coverage

Employer: Lee County Board of County Commissioners

ASA: 881673

SOC: 1A

Issue Date: January 6, 2003

Effective Date: January 1, 2003

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

Eligibility

Employees

You are in an Eligible Class if you are a regular full-time employee and your are in an area in which there are Preferred Care Providers. Your Employer will provide you with this information.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the month coinciding with or next following the date you complete a probationary period of one month of continuous service for your Employer or, if later, the date you enter the Eligible Class.

You can remain in an Eligible Class as a retired employee if you retire under your Employer's IRS Qualified Retirement Plan and will receive a pension, except a deferred vested pension. You may continue your Health Expense Coverage and any coverage you have for your dependents.

If you retired before the Effective Date of this Plan, you are also in an Eligible Class. You must follow the Enrollment Procedure. You may have Health Expense Coverage for you and your dependents.

Dependents

When you join the Plan, your spouse and your dependent children are also eligible to join. A dependent child must be unmarried and under the age of 25. Coverage will continue until end of the year in which the child attains age 25.

You may enroll your natural child, foster child, stepchild, legally adopted child, or a child or grandchild in your court-ordered custody.

Dependents eligible to participate include a lawful spouse, and unmarried children, up to the last day of the calendar year in which they attain age 25 if a full-time/part-time student at an accredited school, college, or university, and dependent upon the employee for support; or, residing in the household of the employee, and dependent upon the employee for support; each unmarried, natural, adopted- from-moment-of-placement in the home, step or foster child, and children under court-appointed legal guardianship, who are either: (a) a full-time or part-time student at an accredited school, college, or university, and dependent upon the employee for support; or, (b) residing in the household of the employee and dependent upon the employee for support.

The newborn child of a covered dependent child is eligible for benefits for up to 18 months of age as long as the parent continues to be a dependent.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

You will get a form to fill out. This form will allow your Employer to deduct your contributions for dependents coverage from your pay. Be sure to sign and return it within 31 days of your eligibility.

Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details. If you are eligible for any coverage as a retired employee, your Employer will advise you concerning the method and amount of any required contributions.

Effective Date of Coverage

Employees

Your coverage will take effect on your Eligibility Date.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions. If you do not do so within 31 days of any dependent's eligibility date, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Note: This Plan will pay a benefit for Covered Medical Expenses incurred by a newborn child during the first 31 days of life, whether or not the child is or becomes enrolled under the Plan.

If the child does not become enrolled under the Plan, coverage will terminate at the end of such 31 day period. Any Extension of Benefits provision will apply. The Continuation of Coverage under Federal Law provision will not apply.

Late Enrollee

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within 31 days of the date the person becomes eligible for such coverage.

Enrollment Procedure

You may elect coverage for a Late Enrollee only during the annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollee will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for the Late Enrollee.

Any preexisting condition limitation will apply to a Late Enrollee.

Exceptions

A person will not be considered to be a Late Enrollee if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:

  the person was covered under other "creditable coverage" as defined below; and

  you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
- the person loses such coverage because:

  of termination of employment in a class eligible for such coverage;

  of reduction in hours of employment;

  your spouse dies;

  you and your spouse divorce or are legally separated;

  such coverage was COBRA continuation and such continuation was exhausted; or

  the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

If you are not considered a Late Enrollee, Health Expense Coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A child who meets the definition of a dependent, but you elect it later in compliance with a court order requiring you to provide such coverage for your dependent child. Such coverage will become effective on the date specified by your Employer. Any limitation as to a preexisting condition may apply.
- A spouse, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.
- Yourself and your spouse and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Retired Employees

In lieu of corresponding rules which apply to employees:

- If any Health Expense Benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when Health Expense Coverage terminates will also apply to you.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Prescription Drug Expense Coverage

Payment Percentage

100% as to:

Preferred Pharmacy	Copay per Prescription or Refill	
	Supply of up to 30 days	Mail Order Drug Supply of over 30 days*
Generic Drugs	$ 10	$ 10
Brand Name Drugs		
On Medication Formulary	$ 20	$ 20
Not on Medication Formulary	$ 35	$ 35

70% as to:

Non-Preferred Pharmacy	
Generic Drugs	$ 10
Brand Name Drugs	
On Medication Formulary	$ 20
Not on Medication Formulary	$ 35

* but no more than a 90 day maximum supply.

Comprehensive Medical Expense Coverage

All maximums included in this Plan are combined maximums between Preferred Care and Non-Preferred Care, where applicable, unless specifically stated otherwise.

Certification Requirement

Certain types of care must be certified as necessary to avoid a reduction in the benefits payable. Read the Comprehensive Medical Expense Coverage section of the Booklet for details of the types of care affected, how to get certification and the effect on your benefits of failure to obtain certification.

Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Skilled Nursing Care.
Excluded Amount $ 500

This Excluded Amount applies separately to each type of admission and care listed above.

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge." See your Employer for a copy of the Directory which lists these health care providers.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Deductible Amounts

Calendar Year Deductible $ 500

When Covered Medical Expenses applied against a person's Calendar Year Deductible in any calendar year equal $ 300, the Calendar Year Deductible will not apply to preferred care or other health care during the rest of that calendar year. Covered Medical Expenses incurred during the rest of that calendar year for preferred care and other health care will not be applied against the person's Calendar Year Deductible.

This Calendar Year Deductible applies to all expenses except:

The following expenses incurred for Non-Preferred Care:

- Hospice Care Expenses
- Emergency use of an Emergency Room
- Expenses incurred as part of the Healthy Outlook Program

The following expenses incurred for Preferred Care:

- Fees of a physician for non-surgical office visits.
- Routine Physical Exam Expenses
- Covered Medical Expenses incurred in connection with Mammograms
- Covered Medical Expenses incurred in connection with Pap Smears

Family Deductible Limit $ 1,000

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal $ 600, the Calendar Year Deductible will not apply to expenses incurred for preferred and other health care during the rest of that calendar year for you and your dependents.

Inpatient Hospital Deductible $ 250

However, for a confinement of a well newborn child that starts on the day of birth, this Inpatient Hospital Deductible will not exceed the hospital's actual charge for board and room for the first day of confinement on which the child's coverage is in force.

This Inpatient Hospital Deductible applies to all Inpatient Hospital Expenses, except those incurred for Preferred Care.

Emergency Room Deductible $ 75 per visit

This Emergency Room Deductible applies to Hospital Expenses incurred for emergency care provided by a Non-Preferred Care Provider. This amount is waived if the person becomes confined in a hospital.

Emergency Room Copay $ 75 per visit

This Emergency Room Copay applies to Hospital Expenses incurred for emergency care provided by a Preferred Care Provider. This amount is waived if the person becomes confined in a hospital.

Payment Percentage

The Payment Percentage applies after any deductible amounts.

For Hospital Expenses

Preferred Care	Non-Preferred Care	Other Health Care
90%	70%	80%

For Physicians Fees

Preferred Care	Non-Preferred Care	Other Health Care
Non-surgical Office Visits - 100% after a $ 10 copay	70%	80%
Other - 90%	70%	80%

For Covered Mammogram Expenses

Preferred Care	Non-Preferred Care	Other Health Care
100%	70%	80%

Physicians Fees for Routine Eye Exam Expenses

Preferred Care	Non-Preferred Care	Other Health Care
Non-surgical Office Visits - 100% after a $ 25 copay	70%	80%
Other - 90%	70%	80%

Physicians Fees for Routine Hearing Exams

Preferred Care	Non-Preferred Care	Other Health Care
Non-surgical Office Visits - 100% after a $ 25 copay	70%	80%
Other - 90%	70%	80%

For Physical Exam Expenses
Refer to applicable category of "***Physician Fees***" above.

For Hospice Care Expenses
The Calendar Year Deductible will be waived for Inpatient Hospice Coverage and Outpatient Hospice Coverage and considered at 100% for Preferred Care and Non-Preferred Care.

For Other Covered Medical Expenses
100% as to:

National Medical Excellence Travel and Lodging Expenses
Expenses authorized under the Healthy Outlook Program
Hospice Care Expenses

80%* as to:

Convalescent Facility Expenses
Home Health Care Expenses
All Other Medical Expenses for which a Payment Percentage is not otherwise shown.

* However, if the providers of services or supplies for which expenses are incurred are of a type that has contracted in sufficient numbers, as determined by Aetna, to furnish services or supplies for a Negotiated Charge, then the Payment Percentage will be the applicable Preferred Care or Non-Preferred Care Payment Percentage as specified above for Hospital Expenses. Such types of providers may include, but are not limited to:

Home Health Care agencies;
Diagnostic laboratories;
Durable Medical Equipment suppliers;
Ambulance services.

To be sure that you will receive the full benefit available under this Plan, you should verify the provider's status by calling either the provider or the toll-free number shown on your ID card.

Reduced Payment Percentage

50% as to:

Non-emergency care in an emergency room.

Payment Percentage and Special Maximums for Alcoholism, Drug Abuse and Mental Disorders

	Preferred Care	Non-Preferred Care	Other Health Care
Alcoholism, Drug Abuse, and Mental Disorders			
Inpatient Treatment	90%	70%	80%
Outpatient Treatment	90%	70%	80%
Special Inpatient Calendar Year Maximum Days	30*		
Special Outpatient Calendar Year Maximum Visits	45*		

*Preferred and Non-Preferred Inpatient Days and Outpatient Visits for Alcoholism, Drug Abuse and Mental Disorders are Combined Maximums.

Payment Limits

These limits apply only to Covered Medical Expenses which are payable at a rate greater than 50% and not applied against any deductible or copay amount.

Payment Limit which Applies to Expenses for a Person

When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach $ 1,000 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches $ 2,000, then benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

Payment Limit which Applies to Expenses for a Family

When a family's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach $ 2,000 in a calendar year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches $ 4,000, then benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

Benefit Maximums

(Read the coverage section in your Booklet for a complete description of the benefits available.)

Convalescent Days	90 per calendar year
Home Health Care Maximum Visits	120 per calendar year
Private Duty Nursing Care Maximum Shifts	70 per calendar year
National Medical Excellence	
Lodging Expenses Maximum	$ 50.00
Travel and Lodging Maximum	$ 10,000
Private Room Limit	The institution's semiprivate rate.

Lifetime Maximum Benefit: There is no Lifetime Maximum Benefit (overall limit) that applies to the Comprehensive Medical benefits described in the Booklet. The only maximum benefit limits are those specifically mentioned in your Booklet.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.

- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer. Any increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

KEEP THIS SUMMARY OF COVERAGE WITH YOUR BOOKLET

Additional Information Provided by
Lee County Board of County Commissioners

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, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) 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 subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

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

Table of Contents

The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the Customer.

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Health Expense Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Comprehensive Dental Expense Coverage

Comprehensive Dental Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all dental care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

This Plan pays benefits for charges for dental services and supplies incurred for treatment of a dental disease or injury. These benefits apply separately to each covered person.

Advance Claim Review

Be sure to read this section carefully.

Before starting a course of treatment for which **dentists'** charges are expected to be $ 350 or more, details of the proposed course of treatment and charges to be made should be filed in acceptable form with Aetna. Your Employer has the proper forms. Aetna will then estimate the benefits. You and the **dentist** will be told what they are before treatment starts.

Some services may be given before Advance Claim Review is made. These are oral exams, including prophylaxis and x-rays and treatment of any traumatic injury or condition which:

- occurs unexpectedly;
- requires immediate diagnosis and treatment; and
- is characterized by symptoms such as severe pain and bleeding.

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending **dentist** as a result of an oral exam. The treatment may be given by one or more **dentists**. The course of treatment starts on the date a **dentist** first gives a service to correct or treat such dental condition.

Note
As a part of Advance Claim Review and as part of proof of any claim:

- Aetna has the right to require an oral exam of the person at its own expense.
- You must give Aetna all diagnostic and evaluative material which it may require. These include x-rays, models, charts and written reports.

The benefits for a course of treatment may be for a lesser amount than would otherwise be paid if Advance Claim Review is not made or if any required verifying material is not furnished. In this event, benefits will be reduced by the amount of Covered Dental Expenses that Aetna cannot verify.

Benefits

This Plan pays a benefit for Covered Dental Expenses equal to the Payment Percentage which applies to:

- Type A expenses;
- Type B expenses;
- Type C expenses; and
- Orthodontic Treatment.

The benefits payable for charges made by a **Preferred Care Provider** is an amount equal to the payment percentage of the **Negotiated Charge** for the service or supply, after any applicable deductible.

The benefit payable for charges made by a provider that is not a **Preferred Care Provider** is an amount equal to the payment percentage of the Covered Dental Expense, after any applicable deductible.

The plan will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for covered expenses. Your are responsible for the deductible.

Covered Dental Expenses

Certain dental expenses are covered. These are the **dentists'** charges for the services and supplies listed below which, for the condition being treated, are:

- **necessary**; and
- customarily used nationwide; and
- deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

This Dental Care Schedule includes only services in the list below.

Alternate Treatment

The next sentence applies if:

- a charge is made for an unlisted service given for the dental care of a specific condition; and
- the list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition.

In that case, the charge will be considered to have been made for a service in the list that Aetna determines would have produced a professionally acceptable result.

Here is a list of Covered Dental Expenses.

Type A Expenses

VISITS AND X-RAYS

- Office visit during regular office hours, for oral examination
  Routine comprehensive or recall examination (limited to 2 visits every year)
  Problem-focused examination (limited to 2 visits every year)
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride (limited to one course of treatment per year and to children under age 16)
- Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 16)
- Bitewing X-rays (limited to one set per year)
- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)

SPACE MAINTAINERS *Includes all adjustments within six months after installation.*

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)

Type B Expenses

VISITS AND EXAMS

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit

X-RAY AND PATHOLOGY

- Single films (up to 13)
- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and histopathologic examination of oral tissue

ORAL SURGERY

- Extractions
  Uncomplicated
  Surgical removal of erupted tooth/root tip
- Impacted Teeth
  Removal of tooth (soft tissue)
- Odontogenic Cysts and Neoplasms
  Incision and drainage of abscess
  Removal of odontogenic cyst or tumor

- Other Surgical Procedures
  - Alveoplasty, in conjunction with extractions - per quadrant
  - Alveoplasty, not in conjunction with extraction - per quadrant
  - Sialolithotomy: removal of salivary calculus
  - Closure of salivary fistula
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Transplantation of tooth or tooth bud
  - Closure of oral fistula of maxillary sinus
  - Sequestrectomy
  - Crown exposure to aid eruption
  - Removal of foreign body from soft tissue
  - Frenectomy
  - Suture of soft tissue injury

PERIODONTICS

- Emergency treatment (periodontal abscess, acute periodontitis, etc.)
- Occlusal adjustment (other than with an appliance or by restoration)
- Subgingival curettage or root planing and scaling, per quadrant, limited to 4 separate quadrants every 2 years
- Gingivectomy (including post-surgical visits) per quadrant, limited to 1 per quadrant every 3 years
- Gingivectomy, treatment per tooth (fewer than 3 teeth), limited to 1 per site, every 3 years
- Gingival flap procedure, including root planing, per quadrant
- Periodontal maintenance

ENDODONTICS

- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root Canal Therapy, including necessary X-rays
  - Anterior
  - Bicuspid
  - Molar

RESTORATIVE DENTISTRY *Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)*

- Amalgam Restorations - Primary Teeth
- Amalgam Restorations - Permanent Teeth
- Resin Restorations
- Sedative Fillings
- Pins
  - Pin retention - per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
- Recementation
  - Inlay
  - Crown
  - Bridge

Type C Expenses

ORAL SURGERY

- Impacted Teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)

PERIODONTICS

- Osseous surgery (including post-surgical visits), per quadrant, limited to 1 per quadrant, every 3 years

RESTORATIVE *Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.*

- Inlays/Onlays - Metallic or Porcelain/Ceramic
  - Inlay, one or more surfaces
  - Onlay, two or more surfaces
- Inlays/Onlays - Resin
  - Inlay, one or more surfaces
  - Onlay, two or more surfaces
- Labial Veneers
  - Laminate-chairside
  - Resin laminate - laboratory
  - Porcelain laminate - laboratory
- Crowns
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - Metallic (3/4 cast)
- Post and core
- Core buildup, including any pins

PROSTHODONTICS

- Bridge Abutments (see Inlays and Crowns)
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
- Removable Bridge (unilateral)
  - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
- Dentures and Partials (Fees for dentures and partial dentures include relines, rebases, and adjustments within six months after installation. Fees for relines and rebases include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.)
  - Complete upper denture

Complete lower denture
Partial upper or lower, resin base (including any conventional clasps, rests, and teeth)
Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests, and teeth)
Stress breakers
Interim partial denture (stayplate), anterior only
Office reline
Laboratory reline
Special tissue conditioning, per denture
Rebase, per denture
Adjustment to denture more than six months after installation

- Full and Partial Denture Repairs
  Broken dentures, no teeth involved
  Repair cast framework
  Replacing missing or broken teeth, each tooth
- Adding teeth to existing partial denture
  Each tooth
  Each clasp
- Repairs: crowns and bridges
- Occlusal guard (for bruxism only) limited to 1 every 3 years

GENERAL ANESTHESIA AND INTRAVENOUS SEDATION *(only when provided in conjunction with a covered surgical procedure).*

ORTHODONTICS

- Comprehensive **orthodontic treatment** of adult or adolescent dentition
- Post Treatment Stabilization
- Removable inhibiting appliance to correct thumbsucking
- Fixed or cemented inhibiting appliance to correct thumbsucking

Special Provisions for Orthodontic Treatments

Coverage for **orthodontic treatment** is limited to those services and supplies listed on the Dental Care Schedule that applies.

Orthodontic coverage is only for covered children who are under age 20 on the date **orthodontic treatment** begins.

A **dentist's** charges for services and supplies for **orthodontic treatment** are included as Covered Orthodontic Expenses. In addition to all other terms of this dental benefit:

- The benefit rate will be the Payment Percentage for **orthodontic treatment.**
- Benefits will not exceed the Orthodontic Maximum for all expenses incurred in his or her lifetime. (It applies even if there is a break in coverage.)

Coverage is not provided for any charges for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before the first day on which the person became a covered person for the benefit.

Coverage is not provided for any charges for an orthodontic procedure for which an active appliance has been installed within the two years starting with the date the person became a covered person for the benefit. This applies only to a person who does not become such a covered person by the 31st day after the first day the person is eligible to become such a covered person.

Explanation of Some Important Plan Provisions

Calendar Year Deductible

This is the amount of Covered Dental Expenses you pay each calendar year before benefits are payable. There is a separate Calendar Year Deductible for each person.

Family Deductible Limit

If Covered Dental Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Calendar Year Maximum Benefit

This Plan has a Calendar Year Maximum Benefit. That is the most that is payable for all dental expenses incurred by a person in a calendar year. It applies even if there is a break in coverage.

Limitations

Alternate Treatment Rule

If more than one service can be used to treat a covered person's dental condition; Aetna may decide to authorize coverage only for a less costly covered service provided that both of the following terms are met:

the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
the service selected must meet broadly accepted national standards of dental practice.

Replacement Rule

The replacement of; addition to; or modification of:

existing dentures;
crowns;
casts or processed restorations;
removable bridges; or
fixed bridgework

is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. Comprehensive Dental Expense Coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast, or processed restoration, removable bridge, or bridgework cannot be made serviceable, and was installed at least 8 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures; removable bridges; and fixed bridgework is subject to the requirements that such dentures; removable bridges; and fixed bridgework are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

Exclusions and Limitations

Covered Dental Expenses do not include and no benefits are payable for charges for:

- Any dental services and supplies which are covered in whole or in part:

  under any other part of this Plan; or

  under any other plan of group benefits provided by your Employer.
- Those for services and supplies to diagnose or treat a disease or **injury** that is not:

  a non-occupational disease; or

  a non-occupational **injury**.
- Those for services not listed in the Dental Care Schedule that applies; except as specifically provided.
- Those for replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Those for:

  dentures;
  crowns;
  inlays;
  onlays;
  bridgework; or
  other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion.
- Those for any of the following services:

  (a) an appliance, or modification of one, if an impression for it was made before the person became a covered person;
  (b) a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
  (c) root canal therapy, if the pulp chamber for it was opened before the person became a covered person.
- Those for services intended for treatment of any **jaw joint disorder**; except as specifically provided.
- Those for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for **orthodontic treatment**; except as specifically provided.
- Those for general anesthesia and intravenous sedation; unless done in conjunction with another **necessary** covered service.
- Those for treatment by other than a **dentist**; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a **dentist**.

- Those in connection with a service given to a person age 5 or more if that person becomes a covered person other than: (i) during the first 31 days the person is eligible for this coverage; or (ii) as prescribed for any period of open enrollment agreed to by the Employer and Aetna. This does not apply to charges incurred:

  (a) after the end of the twelve month period starting on the date the person became a covered person; or
  (b) as a result of accidental **injuries** sustained while the person was a Covered Person; or
  (c) for a Primary Care Service in the Dental Care Schedule that applies shown under the headings Visits and X-rays, Visits and Exams, and X-ray and Pathology.
- Those for a crown; cast; or processed restoration unless:

  (a) it is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
  (b) the tooth is an abutment to a covered partial denture or fixed bridge.
- Those for pontics, crowns, cast or processed restorations made with high noble metals; except as specifically provided.
- Those for surgical removal of impacted wisdom teeth only for orthodontic reasons; except as specifically provided.
- Those for services needed solely in connection with non-covered services.
- Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Benefits After Termination of Coverage

This section applies to a person whose coverage ceases while not "totally disabled". This term is defined in the General Information section.

Dental services given after the covered person's coverage terminates are not covered. However, ordered inlays; onlays; crowns; removable bridges; cast or processed restorations; dentures; fixed bridgework; and root canals will be covered when ordered; if the item is installed or delivered no later than 30 days after coverage terminates.

"Ordered" means that prior to the date coverage ends:

As to a denture:

impressions have been taken from which the denture will be prepared.

As to a root canal:

the pulp chamber was opened.

As to any other item listed above:

the teeth which will serve as retainers or support; or
which are being restored; have been fully prepared to receive the item; and
impressions have been taken from which the item will be prepared.

General Exclusions

General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be 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 disease or injury involved; or

  if required by the FDA, approval has not been granted for marketing; or

  a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; 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, investigational, or for research purposes.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for services and supplies:

  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

  Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)
- Those for routine dental exams or other preventive services and supplies, except to the extent coverage for such exams, services, or supplies is specifically provided in your Booklet.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.

- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to repair an injury. Surgery must be performed:

  in the calendar year of the accident which causes the injury; or

  in the next calendar year.

  Facings on molar crowns and pontics will always be considered cosmetic.
- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service of supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a calendar year, this Plan will pay:

- its regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract B. from A. below:

  A. 100% of "Allowable Expenses" incurred by the person for whom claim is made.
  B. The benefits payable by the "other plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any **necessary** and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made.

The difference between the cost of a private **hospital** room and the **semiprivate rate** is not considered an Allowable Expense under the above definition unless the patient's stay in a private **hospital** room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

      If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

Aetna has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

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

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an Eligible Class and have chosen dental coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Dental Expense Coverage on the date of your coverage under such HMO Plan.

If you are in an Eligible Class and are covered under an HMO Plan providing dental coverage, you can choose to change to coverage for yourself and your covered dependents under this Plan. If you:

- Live in an HMO Plan enrollment area and choose to change dental coverage during an open enrollment period, coverage will take effect on the first day of the contract period which follows the open enrollment period. There will be no rules for waiting periods or preexisting conditions.

- Live in an HMO Plan enrollment area and choose to change dental coverage when there is not an open enrollment period, coverage will take effect only if and when Aetna gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change dental coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change dental coverage after 31 days, coverage will take effect only if and when Aetna gives its written consent.

Any extension of dental benefits under this Plan will not apply on or after the date of a change to an HMO Plan.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

Effect of Prior Coverage - Transferred Business

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next service fee due date following the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 30 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer, but not beyond the end of the calendar month after the calendar month in which the absence started.

The Summary of Coverage may show an Eligible Class of retired employees. If you are in that class, your employment may be deemed to continue:

- for any coverage shown in the Retirement Eligibility section; and
- subject to any limits shown in that section.

If no Eligible Class of retired employees is shown, there is no coverage for retired employees.

If you cease active work, ask your Employer if any coverage can be continued.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under this Plan.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

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 a personal 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; and
- he or she depends chiefly on you for support and maintenance.

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

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.

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.

Health Expense Benefits After Termination

If a person is totally disabled when his or her Health Expense Coverage ceases, benefits will be available to such person while he or she continues to be totally disabled for up to the applicable period shown below.

The words "totally disabled" mean that due to injury or disease:

- You are not able to engage in your customary occupation and are not working for pay or profit.
- Your dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

Comprehensive Dental Expense benefits will be available to him or her while disabled for up to 12 months. The benefits will be available only if expenses are for covered services and supplies which have been rendered and received, including delivered and installed, if these apply, prior to the end of that 12 month period.

Health Expense benefits will cease when the person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.)

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

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

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the Plan Document on file with your Employer. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued as to all or any class of employees.

Assignments

Coverage may be assigned only with the written consent of Aetna.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; 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 this 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 for any benefits is 90 days after the date of the loss causing the claim.

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 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. For all benefits except any Temporary Disability Benefit, written proof must be provided.

All benefits are payable to you. However, this Plan 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.

This Plan may pay up to $ 1,000 of any 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. It can also be done if a benefit is payable to your estate.

Records of Expenses

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

Very important are:

Names of **dentists** who furnish services.
Dates expenses are incurred.
Copies of all bills and receipts.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory

This is a listing of all **Preferred Care Providers** for the class of employees of which you are a member. Copies of this Directory are given to your Employer to give to you. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at www.aetna.com.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

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.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;

- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

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

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge

This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease 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 disease 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.

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.

Not included is:

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

Physician

This means a legally qualified physician.

Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The reasonable 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; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

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

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the 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 prevailing charge in other 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 reasonable charge is the rate established in such agreement.

Semiprivate Rate

This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Continuation of Coverage under Federal Law

The terms of this continuation of coverage provision do not apply to the Plan of any Employer that employs fewer than 20 employees, in accordance with a formula mandated by federal law. Check with your Employer to determine if this continuation of coverage provision applies to this Plan.

In accordance with federal law (PL 99-272) as amended, your Employer is providing covered persons with the right to continue their health expense coverage under certain circumstances.

You or your dependents may continue any health expense coverage then in effect, if coverage would terminate for the reasons specified in sections A, B, or C below. You and your dependents may be required to pay up to 102% of the full cost to the Plan of this continued coverage, or, as to a disabled individual whose coverage is being continued for 29 months in accordance with section A, up to 150% of the full cost to the Plan of this continued coverage for any month after the 18th month.

Subject to the payment of any required contribution, health expense coverage may also be provided for any dependents you acquire while the coverage is being continued. Coverage for these dependents will be subject to the terms of this Plan regarding the addition of new dependents.

Continuation shall be available as follows:

A. Continuation of Coverage on Termination of Employment or Loss of Eligibility

If your coverage would terminate due to:

- termination of your employment for any reason other than gross misconduct; or
- your loss of eligibility under this Plan due to a reduction in the number of hours you work;

you may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue his or her own coverage. This election must include an agreement to pay any required contribution. You or your dependents must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs you or your eligible dependents of any rights under this section.

Coverage will terminate on whichever of the following is the earliest to occur:

- The end of an 18-month period after the date of the event which would have caused coverage to terminate.
- The end of a 29-month period after the date of the event which would have caused coverage to terminate, but only if prior to the end of the above 18-month period, you or your dependent provides notice to your Employer, in accordance with section E below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event which would have caused coverage to terminate. Coverage may be continued: for the individual determined to be disabled; and for any family member (employee or dependent) of the disabled individual, for whom coverage is already being continued; and for your newborn or newly adopted child who was added after the date continued coverage began.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.

- The first day after the date of the election that the individual becomes covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the individual becomes enrolled in benefits under Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.
- As to all individuals whose coverage is being continued in accordance with the terms of the second bulleted item above, the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled individual whose coverage is being so continued is no longer disabled; but in no event shall coverage terminate prior to the end of the 18-month period described in the first bulleted item above.

B. Continuation of Coverage on a Retiree's Loss of Coverage

The Plan Administrator is required to notify a retired employee if his or her former Employer commences a bankruptcy proceeding under Title 11, United States Code. If your coverage as a retired employee would terminate or be substantially eliminated due to this proceeding (or within the 12-month period prior to or following such proceeding), you may be eligible to elect to continue coverage for yourself and your dependents or your dependents may each be eligible to elect to continue his or her own coverage. If you are determined to be eligible, you or your dependents must elect to continue coverage within 60 days of the later to occur of the date the bankruptcy proceedings begin and the date the Plan Administrator informs you or your eligible dependents of any rights under this section. The election must include an agreement to pay any required contribution.

Coverage under this section will terminate on the first to occur of:

- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that the individual becomes covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.

C. Continuation of Coverage Under Other Circumstances

If coverage for a dependent would terminate due to:

- your death;
- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated;
- the dependent's ceasing to be a dependent child as defined under this Plan; or
- the dependent's loss of eligibility under this Plan because you become entitled to benefits under Medicare;

the dependent may elect to continue his or her own coverage. The election to continue coverage must be made within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs your dependents, subject to any notice requirements in section E below, of their continuation rights under this section. The election must include an agreement to pay any required contribution.

Coverage for a dependent will terminate on the first to occur of:

- The end of a 36-month period after the date of the event which would have caused coverage to terminate.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to your dependents under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that the dependent becomes covered under another group health plan. However, continued coverage will not terminate until such time that the dependent is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

D. Multiple Qualifying Events

If coverage for you or your dependents is being continued in accordance with the terms of the above sections A or B, the following shall apply:

- If coverage is being continued for a period specified under section A, and during this period one of the qualifying events under the above section C occurs, this period may be increased. In no event will the total period of continuation provided under this provision for any dependent be more than 36 months.
- If coverage is being continued under section B, and if your death occurs during this continuation, your dependents may elect to continue their coverage for up to 36 months after the date of your death.

Such a qualifying event, however, will not act to extend coverage beyond the original 18-month period under section A, or the date of your death under section B, for any dependents (other than a newborn or newly adopted child) who were added after the date continued coverage began.

E. Notice Requirements

If coverage for you or your dependents:

- is being continued for 18 months in accordance with section A; and
- it is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event in section A which would have caused coverage to terminate;

you or your dependent must notify your Employer of such determination within 60 days after the date of the determination, and within 30 days after the date of any final determination that you or your dependent is no longer disabled.

If coverage for a dependent would terminate due to:

- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated; or
- the dependent's ceasing to be a dependent child as defined under this Plan;

you or your dependent must provide notice to your Employer of the occurrence of the event. This notice must be given within 60 days after the later of the occurrence of the event and the date coverage would terminate due to the occurrence of the event.

If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

F. Other Continuation Provisions Under This Plan

If this Plan contains any other continuation provisions which apply when health expense coverage would otherwise terminate, contact your Employer for a description of how the federal and other continuation provisions interact under this Plan.

G. Conversion

If any coverage being continued under this section terminates because the end of the maximum period of continuation has been reached, any Conversion Privilege will be available at the end of such period on the same terms as are applicable upon termination of employment or upon ceasing to be in an eligible class.

Complete details of the federal continuation provisions may be obtained from your Employer.

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 will 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.

External Review

An "External Review" is a review by an independent physician with appropriate expertise in the area at issue, of claim denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment.

You may, at your option, obtain External Review of a claim denial provided that:

- You have exhausted the Aetna Life Insurance Company appeal process for denied claims, as outlined in the [Claim Procedures] section of this [Booklet], and you have received a final denial;
- The final denial was based upon a lack of medical necessity, or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue exceeds $500.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an External Review at the time the final decision on your internal appeal has been rendered. Either you or an individual acting on your behalf will be required to submit to Aetna Life Insurance Company the External Review Request Form (except under expedited review as described below), a copy of the Plan denial of coverage letter, and all other information you wish to be reviewed in support of your request. Your request for an External Review must be submitted, in writing, to Aetna Life Insurance Company within 60 calendar days after you receive the final decision on your internal appeal.

Aetna Life Insurance Company will contact the "External Review Organization" that will conduct your External Review. The External Review Organization will then select an independent physician with appropriate expertise in the area at issue for the purpose of performing the External Review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the External Review Request Form, and must follow the applicable plan's contractual documents and plan criteria governing the benefits.

The External Review Organization will generally notify you of the decision within 30 calendar days of Aetna Life Insurance Company's receipt of a properly completed External Review Form. The notice will state whether the prior determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer will be binding on the Plan, except where Aetna Life Insurance Company or the Plan can show reviewer conflict of interest, bias, or fraud. In such cases, notice will be given to you and the matter will be promptly resubmitted for consideration by a different reviewer.

An expedited review is available when your treating physician certifies on a separate Request For Expedited External Review form (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30 calendar day period) in receipt of the service or treatment would jeopardize your health. Expedited reviews will be decided within 5 calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna Life Insurance Company. Aetna Life Insurance Company is responsible for the cost of sending this information to the External Review Organization. The professional fee for the External Review will be paid by Aetna U.S. Healthcare.

In order for an individual to act on your behalf in connection with an External Review, you will need to specifically consent to the representation by signing the appropriate line on the External Review Request Form.

You may obtain more information about the External Review process by calling the toll-free Member Services telephone number listed on your ID card.

Table of Contents

The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the Customer.

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Health Expense Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Prescription Drug Expense Coverage

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all **prescription drugs**. There are exclusions, copayment features, fees and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

Covered Prescription Drug Expenses

This Plan pays the benefits shown below for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by a **pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **pharmacy's** charge for the drug is more than the **copay** and fee per **prescription** or refill

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by a **preferred pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the **preferred pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf.

In figuring the benefit amount, a Separate Brand Name Fee applies to **brand name drugs** in addition to any applicable **copay**. The amount of the Separate Brand Name Fee will be equal to the difference between the cost of the **brand name drug** and the generic equivalent. The Separate Brand Name Fee will apply to any **brand name drug** dispensed unless:

- there is no generic equivalent to the **brand name drug**; or
- the **pharmacy** is unable to supply the **generic drug** at the time the **prescription** is presented.

The Benefit Amount for each covered **prescription drug** or refill dispensed by a **non-preferred pharmacy** will be an amount equal to the Payment Percentage of the **non-preferred pharmacy's** charge for the drug except for an **emergency condition**, in which case the benefit will be payable at the preferred level of coverage.

Limitations

No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 30 day supply of any drug dispensed by a **mail order pharmacy**.
- For more than a 30 day supply per **prescription** or refill. However, this limitation does not apply to a supply of up to 90 days per **prescription** or refill for drugs which are provided by a **mail order pharmacy**.
- For the administration or injection of any drug.
- For the following injectable drugs:

  allergy sera or extracts; and

  Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year.
- For any refill of a drug if it is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:

  if the **prescriber** has not specified the number of refills; or

  if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by your Employer.

- For any **prescription drug** also obtainable without a **prescription** on an "over the counter" basis.
- For immunization agents.
- For biological sera and blood products.
- For nutritional supplements.
- For any smoking cessation aids or drugs.
- For appetite suppressants.
- For a **prescription drug** dispensed by a **mail order pharmacy** that is not a **preferred pharmacy**.

Comprehensive Medical Expense Coverage

Comprehensive Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Medical Expenses described below.

Covered Medical Expenses

They are the expenses for certain **hospital** and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

Hospital Expenses

Inpatient Hospital Expenses

Charges made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.

Outpatient Hospital Expenses

Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

Convalescent Facility Expenses

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury. The confinement must start during a "Convalescent Period".

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physician's** services.
- Medical supplies.

Benefits will be paid for up to the maximum number of days during any one Calendar year. This starts on the first day a person is confined in a **convalescent facility** if he or she:

- was confined in a **hospital** for at least 3 days in a row, while covered under this Plan, for treatment of a disease or injury; and
- is confined in the facility within 14 days after discharge from the **hospital**; and
- is confined in the facility for services needed to convalesce from the condition that caused the **hospital** stay. These include skilled nursing and physical restorative services.

It ends when the person has not been confined in a **hospital**, **convalescent facility**, or other place giving nursing care for 90 days in a row.

Limitations To Convalescent Facility Expenses
This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

Home Health Care Expenses

Home health care expenses are covered if:

- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or **convalescent facility**:

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  lab services provided by or for a **home health care agency**.

There is a maximum to the number of visits covered in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Health Care Expenses
This section does not cover charges made 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 wife's or husband's family.
- Services of a social worker.
- Transportation.

Hospice Care Expenses

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses

The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**;
- **convalescent facility**;

which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:

  pain control; and

  other acute and chronic symptom management.
- Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit. Also not included is the charge for any day of confinement in excess of the Maximum Number of Days for all confinements for **Hospice Care**.
- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses

Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:

  assessment of the person's:

  social, emotional, and medical needs; and

  the home and family situation;

  identification of the community resources which are available to the person; and

  assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a **physician**.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.

Charges made by the providers below, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:

  physical and occupational therapy;

  part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  psychological and dietary counseling.

Not more than the Hospice Outpatient Maximum will be paid for all Hospice Care Expenses incurred while the person is not confined as a full-time inpatient.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Contraception Expenses

Covered Medical Expenses include:

- charges incurred for contraceptive drugs and contraceptive devices that by law need a physician's prescription; and that have been approved by the FDA.
- related outpatient contraceptive services such as:

  consultations;
  exams;
  procedures; and
  other medical services and supplies.

Not covered are:

- charges for services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer; and
- charges incurred for contraceptive services while confined as an inpatient.

Infertility Services Expenses

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for infertility if all of the following tests are met:

- There exists a condition that:

  is a demonstrated cause of infertility; and

  has been recognized by a gynecologist or infertility specialist; and

  is not caused by voluntary sterilization or a hysterectomy;

  or

  For a female who is:

  under age 35, she has not been able to conceive after one year or more without contraception or 12 cycles of artificial insemination; or

  age 35 or older, she has not been able to conceive after six months without contraception or 6 cycles of artificial insemination.
- The procedures are performed while not confined in a **hospital** or any other facility as an inpatient.
- FSH levels are less than or equal to 19 miU on day 3 of the menstrual cycle.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

The following infertility services expenses will be Covered Medical Expenses:

- Ovulation induction with ovulatory stimulant drugs, subject to a maximum of 6 courses of treatment in a covered person's lifetime.
- Artificial insemination, subject to a maximum of 6 courses of treatment in a covered person's lifetime.

These expenses will be covered on the same basis as for disease.

A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.

In figuring the above Lifetime Maximums, Aetna will take into consideration, whether past or present, services received while covered, under a plan of benefits offered by Aetna; or one of its affiliated companies.

Not covered are charges for:

- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Cryopreservation or storage of cryopreserved embryos.
- Gestational carrier programs.
- Home ovulation prediction kits.
- In vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection.
- Frozen embryo transfers, including thawing.

Routine Physical Exams

The charges made by a **physician** for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. If charges made by a **physician** in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included as a part of the exam are:

- X-rays, lab, and other tests given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For your dependent child:

- The physical exam must include at least:

  a review and written record of the patient's complete medical history;

  a check of all body systems; and

  a review and discussion of the exam results with the patient or with the parent or guardian.
- For all exams given to your dependent child under age 2, Covered Medical Expenses will not include charges for:

  more than 6 exams performed during the first year of the child's life;

  more than 2 exams performed during the second year of the child's life.
- For all exams given to your dependent child age 2 up to age 18, Covered Medical Expenses will not include charges for more than one exam in 12 months in a row.
- For all exams given to your dependent child age 18 and over, Covered Medical Expenses will not include charges for more than one exam in 24 months in a row.

For all exams given to you and your spouse, Covered Medical Expenses will not include charges for more than:

- one exam in 24 months in a row, if the person is under age 65; and
- one exam in 12 months in a row, if the person is age 65 or over.

Also included as Covered Medical Expenses are charges made by a **physician** for one annual routine gynecological exam.

Not covered are charges for:

- Services which are covered to any extent under any other group plan of your Employer.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a **hospital** or other facility for medical care.
- Services which are not given by a **physician** or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Vision, hearing, or dental exams.
- A **physician's** office visit in connection with immunizations or testing for tuberculosis.

Other Medical Expenses

- Charges made by a **physician.**
- Charges made by a **R.N.** or **L.P.N.** or a nursing agency for skilled nursing care.

  As used here, "skilled nursing care" means these services:

  Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.

  Private duty nursing by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

  Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

  Not included as "skilled nursing care" is:

  that part or all of any nursing care that does not require the education, training, and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs, and companionship activities; or

  any private duty nursing care given while the person is an inpatient in a **hospital** or other health care facility; or

  care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or

  care provided solely for skilled observation except as follows:

  for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:

  change in patient medication;

  need for treatment of an **emergency condition** by a **physician** or the onset of symptoms indicating the likely need for such treatment;

  surgery; or

  release from inpatient confinement; or

  any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

- Charges for the following:

  Drugs and medicines which by law need a **physician's** prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.

  Diagnostic lab work and X-rays.

  X-ray, radium, and radioactive isotope therapy.

  Anesthetics and oxygen.

Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

Repair of purchased equipment.

Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.

Artificial limbs and eyes. Not included are such things as:

eyeglasses;

vision aids;

hearing aids;

communication aids; and

orthopedic shoes, foot orthotics, or other devices to support the feet.

National Medical Excellence Program ® (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

Travel Expenses

These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses

These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum
For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:

  one year after the day the procedure is performed; and

  the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Limitations
Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

Explanation of Some Important Plan Provisions

Inpatient Hospital Deductible
This is the amount of Inpatient Hospital Expenses you pay for each **hospital** confinement of a person.

The Inpatient Hospital Deductible will only be applied once to all **hospital** confinements, regardless of cause, which are separated by less than 10 days.

Expenses used to meet the Inpatient Hospital Deductible cannot be used to meet any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Inpatient Hospital Deductible.

Calendar Year Deductible
This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

Preexisting Conditions

A "preexisting condition" is an injury or disease for which a person:

- received treatment or services; or
- took prescribed drugs or medicines;

during the 180 days right before the person's effective date of coverage (or, if the Plan requires you to serve a probationary period, the 180 days right before the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Summary of Coverage, whichever applies, to determine a person's effective date of coverage.

For the first 365 days following such date, Covered Medical Expenses do not include any expenses for treatment of a preexisting condition.

Special Rules As To A Preexisting Condition

If a person had creditable coverage and such coverage terminated within 90 days prior to the date he or she enrolled (or was enrolled) in this Plan, then any limitation as to a preexisting condition under this Plan will not apply for that person.

Also, if a person enrolls (or is enrolled) in this Plan immediately after any applicable probationary period has been served, and that person had creditable coverage which terminated within 90 days prior to the first day of such probationary period, then any limitation as to a preexisting condition will not apply for that person.

As used above: "creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

Routine Mammogram

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred by a female age 40 or over for one mammogram each calendar year.

Mouth, Jaws, and Teeth

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, **physician** includes a **dentist**.

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out:

  teeth 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.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

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

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the calendar year of the accident or the next one.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only 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.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for routine tooth removal (not needing cutting of bone).

Not included are charges:

- to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, in-mouth scaling, planing or scraping;
- for myofunctional therapy; this is:

  muscle training therapy; or

  training to correct or control harmful habits.

Emergency Room Treatment

Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Payment Percentage.

Non-Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Reduced Payment Percentage.

No benefit will be paid under any other part of this Plan for charges made by a **hospital** for care in an emergency room that is not **emergency care**.

Certification For Hospital Admissions

This certification section applies to admissions other than those for the treatment of alcoholism, drug abuse or **mental disorders**. A separate section applies to such admissions.

If:

- a person becomes confined in a **hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by a **physician** who is a **Preferred Care Provider**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:

  If certification has been requested and denied:

  No benefits will be paid for Hospital Expenses incurred for board and room.

  Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

  No benefits will be paid for Hospital Expenses incurred for board and room.

  As to all other Hospital Expenses:

  Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:

  Hospital Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other Hospital Expenses will be payable at the Payment Percentage.
- As to other Covered Medical Expenses:

  Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied to expenses for **hospital** room and board.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission;** or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician**, or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

Certification For Convalescent Facility Admissions, Home Health Care Expenses, Hospice Care Expenses, and Skilled Nursing Care

If a person incurs Covered Medical Expenses:

- while confined in a **convalescent facility** or a **hospice facility**; or
- for a service or a supply for home health care or hospice care while not confined as an inpatient or skilled nursing care; and

it has not been certified that:

- such confinement or any day of it is **necessary**; or
- such other services or supplies (either specifically or as a part of a planned program of care) are **necessary**, and
- the confinement or service or supply has not been ordered or prescribed by a **physician** who is a **Preferred Care Provider**;

such Covered Medical Expenses will be paid only as follows:

- As to Convalescent Facility Expenses and Hospice Care Facility Expenses incurred while confined in a **convalescent facility** or a **hospice facility**:

  If certification has been requested and denied:

  No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

  Benefits for all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

As to all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:

Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses. Benefits for all other such expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement or (any day of such confinement) is **necessary**:

Convalescent Facility Expenses or Hospice Care Facility Expenses, incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other such expenses, incurred during the confinement, will be paid at the Payment Percentage.

As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.

- As to Covered Medical Expenses incurred for services or supplies either as stated or as a part of a planned program of care for home health care, hospice care while not confined as an inpatient, or skilled nursing care:

  If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not **necessary**, no benefits will be paid for the denied or unnecessary service or supply.

  If certification has not been requested for a service or supply and the service or supply is **necessary**, benefits for the necessary service or supply will be paid as follows:

  Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan; except that:

- To the extent that a day of confinement has been certified, the exclusion of services and supplies because they are not **necessary** will not apply to:

  Convalescent Facility Expenses for room and board; or

  Hospice Care Facility Expenses for room and board.
- To the extent that such service or supply has been certified for home health care, hospice care, or skilled nursing care, the exclusion of services or supplies because they are not **necessary** will not apply to such service or supply.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.
If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies.

Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If:

- services and supplies for hospice care provided to a person have been certified; and
- the person later requires confinement in a **hospital** for pain control or acute symptom management;

any other certification requirement in this plan will be waived for any such day of confinement in a **hospital**.

Certification For Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse or Mental Disorders

If, in connection with the **effective treatment of alcoholism or drug abuse** or treatment of **mental disorders**, a person incurs Covered Medical Expenses while confined in a **hospital** or **treatment facility**; and

- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by a **physician** who is a **Preferred Care Provider:**

Covered Medical Expenses incurred on any day not certified during the confinement will be paid only as follows:

With respect to expenses for **hospital** and **treatment facility** board and room:

If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not **necessary**, no benefits will be paid.

If certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

With respect to all other **hospital** and **treatment facility** expenses:

If certification has been requested and denied, or if certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement is not **necessary**, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded

by any other terms of this Plan; except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not **necessary** will not be applied to **hospital** and **treatment facility** board and room.

To get the days certified, you must call the number shown on your ID card. Such certification must be obtained before confinement as a full-time inpatient, or in the case of an **emergency admission**, within 48 hours after the start of a confinement as a full-time inpatient or as soon as reasonably possible.

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

Treatment of Alcoholism, Drug Abuse, or Mental Disorders

Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment

If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Hospital

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Effective treatment of alcoholism or drug abuse**.
- Treatment of **mental disorders**.

Treatment Facility

Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Other **necessary** services and supplies.

Calendar Year Maximum Benefit
A Special Inpatient Calendar Year Maximum Days applies to the **hospital** and **treatment facility** expenses described above.

Outpatient Treatment
If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital**, **treatment facility** or **physician**, benefits will not be payable for more than the Special Outpatient Calendar Year Maximum Visits in any one calendar year.

General Exclusions

General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be 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 disease or injury involved; or

  if required by the FDA, approval has not been granted for marketing; or

  a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; 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, investigational, or for research purposes.

  However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

  the disease can be expected to cause death within one year, in the absence of effective treatment; and

  the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

  Also, this exclusion will not apply with respect to drugs that:

  have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

  are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

  if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.
- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.

- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.
- Those for services and supplies:

  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

  Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)
- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:

  sildenafil citrate;
  phentolamine;
  apomorphine;
  alprostadil; or
  any other drug that

  is in a similar or identical class,
  has a similar or identical mode of action or exhibits similar or identical outcomes.

  This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in your Booklet.
- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet.

- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

  Improve the function of a part of the body that:

  is not a tooth or structure that supports the teeth; and

  is malformed:

  as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or

  as a direct result of:

  disease; or

  surgery performed to treat a disease or injury.

  Repair an injury. Surgery must be performed:

  in the calendar year of the accident which causes the injury; or

  in the next calendar year.
- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for the reversal of a sterilization procedure.
- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a calendar year, this Plan will pay:

- its regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract B. from A. below:

  A. 100% of "Allowable Expenses" incurred by the person for whom claim is made.
  B. The benefits payable by the "other plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any **necessary** and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made.

The difference between the cost of a private **hospital** room and the **semiprivate rate** is not considered an Allowable Expense under the above definition unless the patient's stay in a private **hospital** room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

      If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

Aetna has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

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

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an Eligible Class and have chosen coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Health Expense Coverage (except Vision Care, if any) on the date of your coverage under such HMO Plan.

If you are in an Eligible Class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this Plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the first day of the contract period which follows the open enrollment period. There will be no rules for waiting periods or preexisting conditions.

- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when Aetna gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when the Aetna gives its written consent.

Any extensions of benefits under this Plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this Plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- the end of a 90 day period; and
- the date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

Effect of Prior Coverage - Transferred Business

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next service fee due date following the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 30 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer, but not beyond the end of the calendar month after the calendar month in which the absence started.

The Summary of Coverage may show an Eligible Class of retired employees. If you are in that class, your employment may be deemed to continue:

- for any coverage shown in the Retirement Eligibility section; and
- subject to any limits shown in that section.

If no Eligible Class of retired employees is shown, there is no coverage for retired employees.

If you cease active work, ask your Employer if any coverage can be continued.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under this Plan.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

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 a personal 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; and
- he or she depends chiefly on you for support and maintenance.

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

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.

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.

Health Expense Benefits After Termination

If a person is totally disabled when his or her Health Expense Coverage ceases, benefits will be available to such person while he or she continues to be totally disabled for up to the applicable period shown below.

The words "totally disabled" mean that due to injury or disease:

- You are not able to engage in your customary occupation and are not working for pay or profit.
- Your dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

Medical Expense benefits will be available to him or her while disabled for up to 12 months.

Health Expense benefits will cease when the person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.)

If this provision applies to you or one of your covered dependents, see the section Conversion of Medical Expense Coverage for information which may affect you.

Conversion of Medical Expense Coverage

This Plan permits certain persons whose Medical Expense Coverage has ceased to convert to a personal medical policy. No medical exam is needed. You and your family members may convert when all coverage ceases because your employment ceases or you cease to be in an eligible class. You may not convert if coverage ceases because the group contract has discontinued as to your medical coverage.

The personal policy may cover:

- you only; or
- you and all of your family members who are covered under this Plan when your coverage ceases; or
- if you die before you retire, all your family members, or your spouse only, who are covered under this Plan when your coverage ceases.

Also, if your own coverage continues, your dependents can apply if they cease to be a dependent as defined in this Plan.

You may convert when you become a retired employee. If this Plan permits retired employees to continue Medical Expense Coverage, and you choose to do so, this conversion privilege will not again be available to you.

The personal policy must be applied for within 31 days after coverage ceases or would otherwise cease without a provision to continue coverage for retired employees. The 31 days start on the date coverage actually ceases even if the person is still eligible for benefits because the person is totally disabled.

Aetna may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:

  any other hospital or surgical expense insurance policy;

  any hospital service or medical expense indemnity corporation subscriber contract;

  any other group contract;

  any statute, welfare plan or program;

  and that with the converted policy, would result in overinsurance or match benefits.

No one has the right to convert if you have been covered under this Plan for less than 3 months. Also, no person has the right to convert if:

- he or she has used up the maximum benefit; or
- he or she becomes eligible for any other Medical Expense Coverage under this Plan.

The personal policy form, and its terms, will be of a type, for group conversion purposes:

- as required by law or regulation; or
- as then offered by Aetna under your Employer's conversion plan.

It will not provide coverage which is the same as coverage under this Plan. The level of coverage may be less and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both of:

- A statement that benefits under it will be cut back by any like benefits payable under this Plan after your coverage ceases.
- A statement that Aetna may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.

The personal policy will state that Aetna has the right to refuse renewal under some conditions. These will be shown in that policy.

If you or your dependent want to convert:

- Your Employer should be asked for a copy of the "Notice of Conversion Privilege and Request" form.
- Send the completed form to the address shown.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply.

The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be Aetna's normal rate for the person's class and age, and the form and amount of coverage.

The personal policy will take effect on the day after coverage terminates under this Plan.

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

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

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the Plan Document on file with your Employer. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued as to all or any class of employees.

Assignments

Coverage may be assigned only with the written consent of Aetna.

Recovery of Benefits Paid

As a condition to payment of benefits under this Plan for expenses incurred by a covered person due to injury or illness for which a third party may be liable:

- The Plan shall, to the extent of benefits it has paid, be subrogated to (has the right to pursue) all rights of recovery of covered persons against:

  such third party; or

  a person's insurance carrier in the event of a claim under the uninsured or underinsured auto coverage provision of an auto insurance policy.
- The Plan shall have the right to recover from the covered person amounts received by judgment, settlement, or otherwise from:

  such third party or his or her insurance carrier; or

  any other person or entity, which includes the auto insurance carrier which provides the covered person's uninsured or underinsured auto insurance coverage.
- The covered person (or person authorized by law to represent the covered person if he or she is not legally capable) shall:

  execute and deliver any documents that are required; and

  do whatever else is necessary to secure such rights.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; 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 this 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 for any benefits is 90 days after the date of the loss causing the claim.

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 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.

All benefits are payable to you. However, this Plan 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.

This Plan may pay up to $ 1,000 of any 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. It can also be done if a benefit is payable to your estate.

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.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Board and Room Charges

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

Brand Name Drug

A **prescription drug** which is protected by trademark registration

Companion

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

  professional nursing care by a **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 **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.
- Makes charges.

Copay

This is a fee, charged to a person, which represents a portion of the applicable expense. It is specified in the Summary of Coverage.

As to a **prescription drug** dispensed by a **preferred pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is dispensed

As to a **prescription drug** dispensed by a **non-preferred pharmacy**, this is the amount by which the total charge for the **prescription drug** is reduced before benefits are payable.

For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed. In no event will the copay be greater than the prescription, kit, or refill.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory

This is a listing of all **Preferred Care Providers** for the class of employees of which you are a member. Copies of this Directory are given to your Employer to give to you. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at www.aetna.com.

Durable Medical and Surgical Equipment

This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Effective Treatment of Alcoholism Or Drug Abuse

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Emergency Admission

One where the **physician** admits the person to the **hospital** or **treatment facility** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:

  placing the person's 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.

Emergency Care

This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, 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, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's 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.

Emergency Condition

This means 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, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's 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.

Generic Drug

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home Health Care Agency

This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or a **R.N.**; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan

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

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

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

This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:

  skilled nursing services; and

  medical social services; and

  psychological and dietary counseling.
- Provides or arranges for other services which will include:

  services of a **physician**; and

  physical and occupational therapy; and

  part-time home health aide services which mainly consist of caring for **terminally ill** persons; and

  inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:

  one **physician**; and

  one **R.N.**; and

  one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- 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.
- Utilizes 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.
- 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

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- 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 such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a **R.N.**
- Has a full-time administrator.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N.

This means a licensed practical nurse.

Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail.

Medication Formulary

A listing of **prescription drugs** which have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both **brand name drugs** and **generic drugs** and is subject to periodic review and modification by Aetna. See your Employer for a current listing.

Mental Disorder

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

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

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

NME Patient

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;

- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

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

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge

This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease 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 disease under such law.

Non-Occupational Injury

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

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

Non-Preferred Care

This is a health care service or supply furnished by a health care provider that is not a **Preferred Care Provider**; if, as determined by Aetna:

- the service or supply could have been provided by a **Preferred Care Provider**; and
- the provider is of a type that falls into one or more of the categories of providers listed in the **Directory**.

Non-Preferred Care Provider

This is:

- a health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**; or
- a **Preferred Care Provider** that is furnishing services or supplies without the referral of a **Primary Care Physician**.

Non-Preferred Pharmacy

A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

Non-urgent Admission

One which is not an **emergency admission** or an **urgent admission.**

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.

Not included is:

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

Other Health Care

This is a health care service or supply that is neither **Preferred Care** nor **Non-Preferred Care.**

Pharmacy

An establishment where **prescription drugs** are legally dispensed.

Physician

This means a legally qualified physician.

Preferred Care

This is a health care service or supply furnished by:

- a **Preferred Care Provider**; or
- a health care provider that is not a **Preferred Care Provider** for an **emergency condition** when travel to a **Preferred Care Provider** is not feasible.

Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

Preferred Pharmacy

A **pharmacy,** including a **mail order pharmacy,** which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

Prescriber

Any person, while 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 of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

Prescription Drugs

Any of the following:

- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

Psychiatric Physician

This is a **physician** who:

- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

R.N.

This means a registered nurse.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The reasonable 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; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

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

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the 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 prevailing charge in other 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 reasonable charge is the rate established in such agreement.

Semiprivate Rate

This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Terminally Ill

This is a medical prognosis of 6 months or less to live.

Treatment Facility (Alcoholism Or Drug Abuse)

This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **effective treatment of alcoholism or drug abuse**.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician**.
- Provides, on the premises, 24 hours a day:

  Detoxification services needed with its effective treatment program.

  Infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.

  Supervision by a staff of **physicians**.

  Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

Treatment Facility (Mental Disorder)

This is an institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of **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 psychiatrist 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 care 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.

Urgent Admission

One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, 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.

Continuation of Coverage under Federal Law

The terms of this continuation of coverage provision do not apply to the Plan of any Employer that employs fewer than 20 employees, in accordance with a formula mandated by federal law. Check with your Employer to determine if this continuation of coverage provision applies to this Plan.

In accordance with federal law (PL 99-272) as amended, your Employer is providing covered persons with the right to continue their health expense coverage under certain circumstances.

You or your dependents may continue any health expense coverage then in effect, if coverage would terminate for the reasons specified in sections A or B below. You and your dependents may be required to pay up to 102% of the full cost to the Plan of this continued coverage, or, as to a disabled individual whose coverage is being continued for 29 months in accordance with section A, up to 150% of the full cost to the Plan of this continued coverage for any month after the 18th month.

Subject to the payment of any required contribution, health expense coverage may also be provided for any dependents you acquire while the coverage is being continued. Coverage for these dependents will be subject to the terms of this Plan regarding the addition of new dependents.

Continuation shall be available as follows:

A. Continuation of Coverage on Termination of Employment or Loss of Eligibility

If your coverage would terminate due to:

- termination of your employment for any reason other than gross misconduct; or
- your loss of eligibility under this Plan due to a reduction in the number of hours you work;

you may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue his or her own coverage. This election must include an agreement to pay any required contribution. You or your dependents must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs you or your eligible dependents of any rights under this section.

Coverage will terminate on whichever of the following is the earliest to occur:

- The end of an 18-month period after the date of the event which would have caused coverage to terminate.
- The end of a 29-month period after the date of the event which would have caused coverage to terminate, but only if prior to the end of the above 18-month period, you or your dependent provides notice to your Employer, in accordance with section D below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event which would have caused coverage to terminate. Coverage may be continued: for the individual determined to be disabled; and for any family member (employee or dependent) of the disabled individual for whom coverage is already being continued; and for your newborn or newly adopted child who was added after the date continued coverage began.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to you under another plan sponsored by your Employer.

- The date any required contributions are not made.
- The first day after the date of the election that the individual becomes covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the individual becomes enrolled in benefits under Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.
- As to all individuals whose coverage is being continued in accordance with the terms of the second bulleted item above, the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled individual whose coverage is being so continued is no longer disabled; but in no event shall such coverage terminate prior to the end of the 18-month period described in the first bulleted item above.

B. Continuation of Coverage Under Other Circumstances

If coverage for a dependent would terminate due to:

- your death;
- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated;
- the dependent's ceasing to be a dependent child as defined under this Plan; or
- the dependent's loss of eligibility under this Plan because you become entitled to benefits under Medicare;

the dependent may elect to continue his or her own coverage. The election to continue coverage must be made within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs your dependents, subject to any notice requirements in section D below, of their continuation rights under this section. The election must include an agreement to pay any required contribution.

Coverage for a dependent will terminate on the first to occur of:

- The end of a 36-month period after the date of the event which would have caused coverage to terminate.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to your dependents under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that the dependent becomes covered under another group health plan. However, continued coverage will not terminate until such time that the dependent is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

C. Multiple Qualifying Events

If coverage for you or your dependents is being continued for a period specified under section A, and during this period one of the qualifying events under the above section B occurs, this period may be increased. In no event will the total period of continuation provided under this provision for any dependent be more than 36 months.

Such a qualifying event, however, will not act to extend coverage beyond the original 18-month period for any dependents (other than a newborn or newly adopted child) who were added after the date continued coverage began.

D. Notice Requirements

If coverage for you or your dependents:

- is being continued for 18 months in accordance with section A; and
- it is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event in section A which would have caused coverage to terminate;

you or your dependent must notify your Employer of such determination within 60 days after the date of the determination, and within 30 days after the date of any final determination that you or your dependent is no longer disabled.

If coverage for a dependent would terminate due to:

- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated; or
- the dependent's ceasing to be a dependent child as defined under this Plan;

you or your dependent must provide notice to your Employer of the occurrence of the event. This notice must be given within 60 days after the later of the occurrence of the event and the date coverage would terminate due to the occurrence of the event.

If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

E. Other Continuation Provisions Under This Plan

If this Plan contains any other continuation provisions which apply when health expense coverage would otherwise terminate, contact your Employer for a description of how the federal and other continuation provisions interact under this Plan.

F. Conversion

If any coverage being continued under this section terminates because the end of the maximum period of continuation has been reached, any Conversion Privilege will be available at the end of such period on the same terms as are applicable upon termination of employment or upon ceasing to be in an eligible class.

Complete details of the federal continuation provisions may be obtained from your Employer.

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 will 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.

External Review

An "External Review" is a review by an independent physician with appropriate expertise in the area at issue, of claim denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment.

You may, at your option, obtain External Review of a claim denial provided that:

- You have exhausted the Aetna Life Insurance Company appeal process for denied claims, as outlined in the [Claim Procedures] section of this [Booklet], and you have received a final denial;
- The final denial was based upon a lack of medical necessity, or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue exceeds $500.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an External Review at the time the final decision on your internal appeal has been rendered. Either you or an individual acting on your behalf will be required to submit to Aetna Life Insurance Company the External Review Request Form (except under expedited review as described below), a copy of the Plan denial of coverage letter, and all other information you wish to be reviewed in support of your request. Your request for an External Review must be submitted, in writing, to Aetna Life Insurance Company within 60 calendar days after you receive the final decision on your internal appeal.

Aetna Life Insurance Company will contact the "External Review Organization" that will conduct your External Review. The External Review Organization will then select an independent physician with appropriate expertise in the area at issue for the purpose of performing the External Review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the External Review Request Form, and must follow the applicable plan's contractual documents and plan criteria governing the benefits.

The External Review Organization will generally notify you of the decision within 30 calendar days of Aetna Life Insurance Company's receipt of a properly completed External Review Form. The notice will state whether the prior determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer will be binding on the Plan, except where Aetna Life Insurance Company or the Plan can show reviewer conflict of interest, bias, or fraud. In such cases, notice will be given to you and the matter will be promptly resubmitted for consideration by a different reviewer.

An expedited review is available when your treating physician certifies on a separate Request For Expedited External Review form (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30 calendar day period) in receipt of the service or treatment would jeopardize your health. Expedited reviews will be decided within 5 calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna Life Insurance Company. Aetna Life Insurance Company is responsible for the cost of sending this information to the External Review Organization. The professional fee for the External Review will be paid by Aetna U.S. Healthcare.

In order for an individual to act on your behalf in connection with an External Review, you will need to specifically consent to the representation by signing the appropriate line on the External Review Request Form.

You may obtain more information about the External Review process by calling the toll-free Member Services telephone number listed on your ID card.

Table of Contents

The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the Customer.

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Health Expense Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Prescription Drug Expense Coverage

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all **prescription drugs**. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

Covered Prescription Drug Expenses

This Plan pays the benefits shown below for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by a **pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **pharmacy's** charge for the drug is more than the **copay** per **prescription** or refill.

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by a **preferred pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the **preferred pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf.

The Benefit Amount for each covered **prescription drug** or refill dispensed by a **non-preferred pharmacy** will be an amount equal to the Payment Percentage of the **non-preferred pharmacy's** charge for the drug except for an **emergency condition**, in which case the benefit will be payable at the preferred level of coverage.

Limitations

No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 30 day supply of any drug dispensed by a **mail order pharmacy**.
- For more than a 30 day supply per **prescription** or refill. However, this limitation does not apply to a supply of up to 90 days per **prescription** or refill for drugs which are provided by a **mail order pharmacy**.
- For the administration or injection of any drug.
- For the following injectable drugs:

  allergy sera or extracts; and

  Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year.
- For any refill of a drug if it is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:

  if the **prescriber** has not specified the number of refills; or

  if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by your Employer.
- For any **prescription drug** also obtainable without a **prescription** on an "over the counter" basis.
- For immunization agents.
- For biological sera and blood products.
- For nutritional supplements.
- For any smoking cessation aids or drugs.
- For appetite suppressants.
- For a **prescription drug** dispensed by a **mail order pharmacy** that is not a **preferred pharmacy**.

Comprehensive Medical Expense Coverage

Comprehensive Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Medical Expenses described below.

Covered Medical Expenses

They are the expenses for certain **hospital** and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

Hospital Expenses

Inpatient Hospital Expenses

Charges made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.

Outpatient Hospital Expenses

Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

Convalescent Facility Expenses

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury. The confinement must start during a "Convalescent Period".

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physician's** services.
- Medical supplies.

Benefits will be paid for up to the maximum number of days during any one Calendar Year. This starts on the first day a person is confined in a **convalescent facility** if he or she:

- was confined in a **hospital** for at least 3 days in a row, while covered under this Plan, for treatment of a disease or injury; and
- is confined in the facility within 14 days after discharge from the **hospital**; and
- is confined in the facility for services needed to convalesce from the condition that caused the **hospital** stay. These include skilled nursing and physical restorative services.

Limitations To Convalescent Facility Expenses
This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

Home Health Care Expenses

Home health care expenses are covered if:

- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or **convalescent facility**:

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  lab services provided by or for a **home health care agency**.

There is a maximum to the number of visits covered in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Health Care Expenses
This section does not cover charges made 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 wife's or husband's family.
- Services of a social worker.
- Transportation.

Hospice Care Expenses

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses
The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**;
- **convalescent facility**;

which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:

  pain control; and

  other acute and chronic symptom management.
- Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses
Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:

  assessment of the person's:

  social, emotional, and medical needs; and

  the home and family situation;

  identification of the community resources which are available to the person; and

  assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a **physician**.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.

Charges made by the providers below, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:

  physical and occupational therapy;

  part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  psychological and dietary counseling.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Contraception Expenses

Covered Medical Expenses include:

- charges incurred for contraceptive drugs and contraceptive devices that by law need a physician's prescription; and that have been approved by the FDA.
- related outpatient contraceptive services such as:

  consultations;
  exams;
  procedures; and
  other medical services and supplies.

Not covered are:

- charges for services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer; and
- charges incurred for contraceptive services while confined as an inpatient.

Infertility Services Expenses

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for infertility if all of the following tests are met:

- There exists a condition that:

  is a demonstrated cause of infertility; and

  has been recognized by a gynecologist or infertility specialist; and

  is not caused by voluntary sterilization or a hysterectomy;

  or

  For a female who is:

  under age 35, she has not been able to conceive after one year or more without contraception or 12 cycles of artificial insemination; or

  age 35 or older, she has not been able to conceive after six months without contraception or 6 cycles of artificial insemination.
- The procedures are performed while not confined in a **hospital** or any other facility as an inpatient.

- FSH levels are less than or equal to 19 miU on day 3 of the menstrual cycle.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

The following infertility services expenses will be Covered Medical Expenses:

- Ovulation induction with ovulatory stimulant drugs, subject to a maximum of 6 courses of treatment in a covered person's lifetime.
- Artificial insemination, subject to a maximum of 6 courses of treatment in a covered person's lifetime.

These expenses will be covered on the same basis as for disease.

A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.

In figuring the above Lifetime Maximums, Aetna will take into consideration, whether past or present, services received while covered, under a plan of benefits offered by Aetna; or one of its affiliated companies.

Not covered are charges for:

- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Cryopreservation or storage of cryopreserved embryos.
- Gestational carrier programs.
- Home ovulation prediction kits.
- In vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection.
- Frozen embryo transfers, including thawing.

Routine Physical Exams

The charges made by a **physician** for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. If charges made by a **physician** in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included as a part of the exam are:

- X-rays, lab, and other tests given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For your dependent child:

- The physical exam must include at least:

  a review and written record of the patient's complete medical history;

  a check of all body systems; and

  a review and discussion of the exam results with the patient or with the parent or guardian.

- For all exams given to your dependent child under age 2, Covered Medical Expenses will not include charges for:

  more than 6 exams performed during the first year of the child's life;

  more than 2 exams performed during the second year of the child's life.
- For all exams given to your dependent child age 2 up to age 18, Covered Medical Expenses will not include charges for more than one exam in 12 months in a row.
- For all exams given to your dependent child age 18 and over, Covered Medical Expenses will not include charges for more than one exam in 24 months in a row.

For all exams given to you and your spouse, Covered Medical Expenses will not include charges for more than:

- one exam in 24 months in a row, if the person is under age 65; and
- one exam in 12 months in a row, if the person is age 65 or over.

Also included as Covered Medical Expenses are charges made by a **physician** for one annual routine gynecological exam.

Not covered are charges for:

- Services which are covered to any extent under any other group plan of your Employer.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a **hospital** or other facility for medical care.
- Services which are not given by a **physician** or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Vision, hearing, or dental exams.
- A **physician's** office visit in connection with immunizations or testing for tuberculosis.

Vision Care Services Expense Benefits

Covered Medical Expenses include charges for any service shown below which is furnished by a legally qualified ophthalmologist or optometrist to a person.

Routine Eye Exam Expenses

Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.

Covered Medical Expenses will not include charges for more than one routine eye exam for any period of 12 months in a row.

Limitations

The following limitations apply.

No benefits will be payable for a charge which is:

- For any eye exam to diagnose or treat a disease or injury.
- For drugs or medicines.
- For a vision care service that is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer.

- For a vision care service for which a benefit is provided in whole or in part under any workers' compensation law or any other law of like purpose.
- For special procedures. This means things such as orthoptics or vision training.
- For any vision care supply.
- For an eye exam which:

  is required by an employer as a condition of employment; or

  an employer is required to provide under a labor agreement; or

  is required by any law of a government.

- For a service received while the person is not covered.
- For a service or supply which does not meet professionally accepted standards.
- For any exams given while the person is confined in a **hospital** or other facility for medical care.
- For an eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses

Routine Hearing Exam Expenses

Covered Medical Expenses include charges for an audiometric exam. The services must be performed by: a Physician certified as an otolaryngologist or otologist; or

an audiologist who either:

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

who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Covered Medical Expenses will not include charges for more than one hearing exam for any period of 24 months in a row.

Benefits for the Routine Hearing Exam are subject to the applicable deductible or copay and payment percentage shown in the Summary of Coverage.

Limitations

Not included are charges for:

- any ear or hearing exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- any hearing care service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered;

- any exams given while the person is confined in a **hospital** or other facility for medical care;
- any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government.

Other Medical Expenses

- Charges made by a **physician.**
- Charges made by a **R.N.** or **L.P.N.** or a nursing agency for skilled nursing care.

As used here, "skilled nursing care" means these services:

Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.

Private duty nursing by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Not included as "skilled nursing care" is:

that part or all of any nursing care that does not require the education, training, and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs, and companionship activities; or

any private duty nursing care given while the person is an inpatient in a **hospital** or other health care facility; or

care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or

care provided solely for skilled observation except as follows:

for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:

change in patient medication;

need for treatment of an **emergency condition** by a **physician** or the onset of symptoms indicating the likely need for such treatment;

surgery; or

release from inpatient confinement; or

any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

- Charges for the following:

  Drugs and medicines which by law need a **physician's** prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.

  Diagnostic lab work and X-rays.

  X-ray, radium, and radioactive isotope therapy.

  Anesthetics and oxygen.

  Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

  The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

  Repair of purchased equipment.

  Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

  Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.

  Artificial limbs and eyes. Not included are such things as:

  eyeglasses;

  vision aids;

  hearing aids;

  communication aids; and

  orthopedic shoes, foot orthotics, or other devices to support the feet.

National Medical Excellence Program ® (NME)

The NME program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

Travel Expenses

These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses
These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum
For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:

  one year after the day the procedure is performed; and

  the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Limitations
Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient.**

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

Healthy Outlook Program

This is a disease management program for covered persons with one or more of the following chronic conditions:

- asthma;
- congestive heart failure;
- coronary artery disease;
- diabetes; and
- low back pain.

A "participant" in this program is a covered person:

- who has identified himself or herself; or
- who has been identified by:

  his or her attending physician or other health care provider; or

  Aetna; or

  his or her Employer; and
- who is approved by Aetna as a participant.

Any visit or day calendar year maximum, or visit or day lifetime maximum under this Plan will not be reduced. However, any dollar calendar year maximum or dollar lifetime maximum under this Plan will be reduced. Any applicable deductible will be waived.

Explanation of Some Important Plan Provisions

Inpatient Hospital Deductible

This is the amount of Inpatient Hospital Expenses you pay for each **hospital** confinement of a person.

The Inpatient Hospital Deductible will only be applied once to all **hospital** confinements, regardless of cause, which are separated by less than 10 days.

Expenses used to meet the Inpatient Hospital Deductible cannot be used to meet any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Inpatient Hospital Deductible.

Calendar Year Deductible

This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

Family Deductible Limit

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Preexisting Conditions

A "preexisting condition" is an injury or disease for which a person:

- received treatment or services; or
- took prescribed drugs or medicines;

during the 180 days right before the person's effective date of coverage (or, if the Plan requires you to serve a probationary period, the 180 days right before the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Summary of Coverage, whichever applies, to determine a person's effective date of coverage.

For the first 365 days following such date, Covered Medical Expenses do not include any expenses for treatment of a preexisting condition.

Special Rules As To A Preexisting Condition

If a person had creditable coverage and such coverage terminated within 90 days prior to the date he or she enrolled (or was enrolled) in this Plan, then any limitation as to a preexisting condition under this Plan will not apply for that person.

Also, if a person enrolls (or is enrolled) in this Plan immediately after any applicable probationary period has been served, and that person had creditable coverage which terminated within 90 days prior to the first day of such probationary period, then any limitation as to a preexisting condition will not apply for that person.

As used above: "creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

Routine Mammogram

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred by a female age 40 or over for one mammogram each calendar year.

Mouth, Jaws, and Teeth

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, **physician** includes a **dentist**.

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out:

  teeth 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.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

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

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the calendar year of the accident or the next one.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only 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.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for routine tooth removal (not needing cutting of bone).

Not included are charges:

- to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, in-mouth scaling, planing or scraping;
- for myofunctional therapy; this is:

  muscle training therapy; or

  training to correct or control harmful habits.

Non-Emergency Care In An Emergency Room

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Reduced Payment Percentage.

No benefit will be paid under any other part of this Plan for charges made by a **hospital** for care in an emergency room that is not **emergency care**.

Certification For Hospital Admissions

If:

- a person becomes confined in a **hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:

  If certification has been requested and denied:

  No benefits will be paid for Hospital Expenses incurred for board and room.

  Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

  No benefits will be paid for Hospital Expenses incurred for board and room.

  As to all other Hospital Expenses:

  Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:

Hospital Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Hospital Expenses will be payable at the Payment Percentage.

- As to other Covered Medical Expenses:

Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied to expenses for **hospital** room and board.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission;** or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician**, or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

Treatment of Alcoholism, Drug Abuse, or Mental Disorders

Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment

If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Hospital

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.

- **Effective treatment of alcoholism or drug abuse**.
- Treatment of **mental disorders**.

Treatment Facility

Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Other **necessary** services and supplies.

Calendar Year Maximum Benefit

A Special Inpatient Calendar Year Maximum Days applies to the **hospital** and **treatment facility** expenses described above.

Outpatient Treatment

If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital**, **treatment facility** or **physician**, benefits will not be payable for more than the Special Outpatient Calendar Year Maximum Visits in any one calendar year.

General Exclusions

General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be 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 disease or injury involved; or
  if required by the FDA, approval has not been granted for marketing; or

  a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; 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, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

the disease can be expected to cause death within one year, in the absence of effective treatment; and

the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.
- Those for services and supplies:

  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:

  sildenafil citrate;
  phentolamine;
  apomorphine;
  alprostadil; or
  any other drug that

    is in a similar or identical class,
    has a similar or identical mode of action or exhibits similar or identical outcomes.

  This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in your Booklet.
- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

  Improve the function of a part of the body that:

    is not a tooth or structure that supports the teeth; and

is malformed:

as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or

as a direct result of:

disease; or

surgery performed to treat a disease or injury.

Repair an injury. Surgery must be performed:

in the calendar year of the accident which causes the injury; or

in the next calendar year.

- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for the reversal of a sterilization procedure.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a calendar year, this Plan will pay:

- its regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract B. from A. below:

  A. 100% of "Allowable Expenses" incurred by the person for whom claim is made.
  B. The benefits payable by the "other plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any **necessary** and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made.

The difference between the cost of a private **hospital** room and the **semiprivate rate** is not considered an Allowable Expense under the above definition unless the patient's stay in a private **hospital** room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

      If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

Aetna has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

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

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an Eligible Class and have chosen coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Health Expense Coverage (except Vision Care, if any) on the date of your coverage under such HMO Plan.

If you are in an Eligible Class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this Plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the first day of the contract period which follows the open enrollment period. There will be no rules for waiting periods or preexisting conditions.

- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when Aetna gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when the Aetna gives its written consent.

Any extensions of benefits under this Plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this Plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- the end of a 90 day period; and
- the date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

Effect of Prior Coverage - Transferred Business

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next service fee due date following the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 30 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer, but not beyond the end of the calendar month after the calendar month in which the absence started.

The Summary of Coverage may show an Eligible Class of retired employees. If you are in that class, your employment may be deemed to continue:

- for any coverage shown in the Retirement Eligibility section; and
- subject to any limits shown in that section.

If no Eligible Class of retired employees is shown, there is no coverage for retired employees.

If you cease active work, ask your Employer if any coverage can be continued.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under this Plan.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

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 a personal 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; and
- he or she depends chiefly on you for support and maintenance.

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

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.

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.

Health Expense Benefits After Termination

If a person is totally disabled when his or her Health Expense Coverage ceases, benefits will be available to such person while he or she continues to be totally disabled for up to the applicable period shown below.

The words "totally disabled" mean that due to injury or disease:

- You are not able to engage in your customary occupation and are not working for pay or profit.
- Your dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

Medical Expense benefits will be available to him or her while disabled for up to 12 months.

Health Expense benefits will cease when the person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.)

If this provision applies to you or one of your covered dependents, see the section Conversion of Medical Expense Coverage for information which may affect you.

Conversion of Medical Expense Coverage

This Plan permits certain persons whose Medical Expense Coverage has ceased to convert to a personal medical policy. No medical exam is needed. You and your family members may convert when all coverage ceases because your employment ceases or you cease to be in an eligible class. You may not convert if coverage ceases because the group contract has discontinued as to your medical coverage.

The personal policy may cover:

- you only; or
- you and all of your family members who are covered under this Plan when your coverage ceases; or
- if you die before you retire, all your family members, or your spouse only, who are covered under this Plan when your coverage ceases.

Also, if your own coverage continues, your dependents can apply if they cease to be a dependent as defined in this Plan.

You may convert when you become a retired employee. If this Plan permits retired employees to continue Medical Expense Coverage, and you choose to do so, this conversion privilege will not again be available to you.

The personal policy must be applied for within 31 days after coverage ceases or would otherwise cease without a provision to continue coverage for retired employees. The 31 days start on the date coverage actually ceases even if the person is still eligible for benefits because the person is totally disabled.

Aetna may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:

  any other hospital or surgical expense insurance policy;

  any hospital service or medical expense indemnity corporation subscriber contract;

  any other group contract;

  any statute, welfare plan or program;

  and that with the converted policy, would result in overinsurance or match benefits.

No one has the right to convert if you have been covered under this Plan for less than 3 months. Also, no person has the right to convert if:

- he or she has used up the maximum benefit; or
- he or she becomes eligible for any other Medical Expense Coverage under this Plan.

The personal policy form, and its terms, will be of a type, for group conversion purposes:

- as required by law or regulation; or
- as then offered by Aetna under your Employer's conversion plan.

It will not provide coverage which is the same as coverage under this Plan. The level of coverage may be less and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both of:

- A statement that benefits under it will be cut back by any like benefits payable under this Plan after your coverage ceases.
- A statement that Aetna may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.

The personal policy will state that Aetna has the right to refuse renewal under some conditions. These will be shown in that policy.

If you or your dependent want to convert:

- Your Employer should be asked for a copy of the "Notice of Conversion Privilege and Request" form.
- Send the completed form to the address shown.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply.

The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be Aetna's normal rate for the person's class and age, and the form and amount of coverage.

The personal policy will take effect on the day after coverage terminates under this Plan.

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

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

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the Plan Document on file with your Employer. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued as to all or any class of employees.

Assignments

Coverage may be assigned only with the written consent of Aetna.

Recovery of Benefits Paid

As a condition to payment of benefits under this Plan for expenses incurred by a covered person due to injury or illness for which a third party may be liable:

- The Plan shall, to the extent of benefits it has paid, be subrogated to (has the right to pursue) all rights of recovery of covered persons against:

  such third party; or

  a person's insurance carrier in the event of a claim under the uninsured or underinsured auto coverage provision of an auto insurance policy.
- The Plan shall have the right to recover from the covered person amounts received by judgment, settlement, or otherwise from:

  such third party or his or her insurance carrier; or

  any other person or entity, which includes the auto insurance carrier which provides the covered person's uninsured or underinsured auto insurance coverage.
- The covered person (or person authorized by law to represent the covered person if he or she is not legally capable) shall:

  execute and deliver any documents that are required; and

  do whatever else is necessary to secure such rights.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; 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 this 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 for any benefits is 90 days after the date of the loss causing the claim.

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 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. For all benefits except any Temporary Disability Benefit, written proof must be provided.

All benefits are payable to you. However, this Plan 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.

This Plan may pay up to $ 1,000 of any 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. It can also be done if a benefit is payable to your estate.

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.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Board and Room Charges

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

Brand Name Drug

A **prescription drug** which is protected by trademark registration

Companion

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

  professional nursing care by a **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 **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.
- Makes charges.

Copay

This is a fee, charged to a person, which represents a portion of the applicable expense. It is specified in the Summary of Coverage.

As to a **prescription drug** dispensed by a **preferred pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is dispensed

As to a **prescription drug** dispensed by a **non-preferred pharmacy**, this is the amount by which the total charge for the **prescription drug** is reduced before benefits are payable.

For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed. In no event will the copay be greater than the prescription, kit, or refill.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Durable Medical and Surgical Equipment

This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Effective Treatment of Alcoholism Or Drug Abuse

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Emergency Admission

One where the **physician** admits the person to the **hospital** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:

  placing the person's 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.

Emergency Care

This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, 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, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's 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.

Emergency Condition

This means 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, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's 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.

Generic Drug

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home Health Care Agency

This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or a **R.N.**; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan

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

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

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

This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:

  skilled nursing services; and

  medical social services; and

  psychological and dietary counseling.
- Provides or arranges for other services which will include:

  services of a **physician**; and

  physical and occupational therapy; and

  part-time home health aide services which mainly consist of caring for **terminally ill** persons; and

  inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:

  one **physician**; and

  one **R.N.**; and

  one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- 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.
- Utilizes 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.
- 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

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- 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 such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a **R.N.**
- Has a full-time administrator.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N.

This means a licensed practical nurse.

Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail.

Medication Formulary

A listing of **prescription drugs** which have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both **brand name drugs** and **generic drugs** and is subject to periodic review and modification by Aetna. See your Employer for a current listing.

Mental Disorder

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

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

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

NME Patient

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;

- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

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

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease 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 disease under such law.

Non-Occupational Injury

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

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

Non-Preferred Care Provider

This is:

- a health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**; or
- a **Preferred Care Provider** that is furnishing services or supplies without the referral of a **Primary Care Physician**.

Non-Preferred Pharmacy

A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

Non-urgent Admission

One which is not an **emergency admission** or an **urgent admission**.

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.

Not included is:

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

Pharmacy

An establishment where **prescription drugs** are legally dispensed.

Physician

This means a legally qualified physician.

Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

Preferred Pharmacy

A **pharmacy,** including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

Prescriber

Any person, while 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 of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

Prescription Drugs

Any of the following:

- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

Psychiatric Physician

This is a **physician** who:

- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

R.N.

This means a registered nurse.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The reasonable 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; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

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

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the 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 prevailing charge in other 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 reasonable charge is the rate established in such agreement.

Semiprivate Rate

This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Terminally Ill

This is a medical prognosis of 6 months or less to live.

Treatment Facility (Alcoholism Or Drug Abuse)

This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **effective treatment of alcoholism or drug abuse**.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician**.
- Provides, on the premises, 24 hours a day:

  Detoxification services needed with its effective treatment program.

  Infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.

  Supervision by a staff of **physicians**.

  Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

Urgent Admission

One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, 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.

Continuation of Coverage under Federal Law

The terms of this continuation of coverage provision do not apply to the Plan of any Employer that employs fewer than 20 employees, in accordance with a formula mandated by federal law. Check with your Employer to determine if this continuation of coverage provision applies to this Plan.

In accordance with federal law (PL 99-272) as amended, your Employer is providing covered persons with the right to continue their health expense coverage under certain circumstances.

You or your dependents may continue any health expense coverage then in effect, if coverage would terminate for the reasons specified in sections A, B, or C below. You and your dependents may be required to pay up to 102% of the full cost to the Plan of this continued coverage, or, as to a disabled individual whose coverage is being continued for 29 months in accordance with section A, up to 150% of the full cost to the Plan of this continued coverage for any month after the 18th month.

Subject to the payment of any required contribution, health expense coverage may also be provided for any dependents you acquire while the coverage is being continued. Coverage for these dependents will be subject to the terms of this Plan regarding the addition of new dependents.

Continuation shall be available as follows:

A. Continuation of Coverage on Termination of Employment or Loss of Eligibility

If your coverage would terminate due to:

- termination of your employment for any reason other than gross misconduct; or
- your loss of eligibility under this Plan due to a reduction in the number of hours you work;

you may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue his or her own coverage. This election must include an agreement to pay any required contribution. You or your dependents must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs you or your eligible dependents of any rights under this section.

Coverage will terminate on whichever of the following is the earliest to occur:

- The end of an 18-month period after the date of the event which would have caused coverage to terminate.
- The end of a 29-month period after the date of the event which would have caused coverage to terminate, but only if prior to the end of the above 18-month period, you or your dependent provides notice to your Employer, in accordance with section E below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event which would have caused coverage to terminate. Coverage may be continued: for the individual determined to be disabled; and for any family member (employee or dependent) of the disabled individual, for whom coverage is already being continued; and for your newborn or newly adopted child who was added after the date continued coverage began.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.

- The first day after the date of the election that the individual becomes covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the individual becomes enrolled in benefits under Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.
- As to all individuals whose coverage is being continued in accordance with the terms of the second bulleted item above, the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled individual whose coverage is being so continued is no longer disabled; but in no event shall coverage terminate prior to the end of the 18-month period described in the first bulleted item above.

B. Continuation of Coverage on a Retiree's Loss of Coverage

The Plan Administrator is required to notify a retired employee if his or her former Employer commences a bankruptcy proceeding under Title 11, United States Code. If your coverage as a retired employee would terminate or be substantially eliminated due to this proceeding (or within the 12-month period prior to or following such proceeding), you may be eligible to elect to continue coverage for yourself and your dependents or your dependents may each be eligible to elect to continue his or her own coverage. If you are determined to be eligible, you or your dependents must elect to continue coverage within 60 days of the later to occur of the date the bankruptcy proceedings begin and the date the Plan Administrator informs you or your eligible dependents of any rights under this section. The election must include an agreement to pay any required contribution.

Coverage under this section will terminate on the first to occur of:

- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that the individual becomes covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.

C. Continuation of Coverage Under Other Circumstances

If coverage for a dependent would terminate due to:

- your death;
- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated;
- the dependent's ceasing to be a dependent child as defined under this Plan; or
- the dependent's loss of eligibility under this Plan because you become entitled to benefits under Medicare;

the dependent may elect to continue his or her own coverage. The election to continue coverage must be made within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs your dependents, subject to any notice requirements in section E below, of their continuation rights under this section. The election must include an agreement to pay any required contribution.

Coverage for a dependent will terminate on the first to occur of:

- The end of a 36-month period after the date of the event which would have caused coverage to terminate.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to your dependents under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that the dependent becomes covered under another group health plan. However, continued coverage will not terminate until such time that the dependent is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

D. Multiple Qualifying Events

If coverage for you or your dependents is being continued in accordance with the terms of the above sections A or B, the following shall apply:

- If coverage is being continued for a period specified under section A, and during this period one of the qualifying events under the above section C occurs, this period may be increased. In no event will the total period of continuation provided under this provision for any dependent be more than 36 months.
- If coverage is being continued under section B, and if your death occurs during this continuation, your dependents may elect to continue their coverage for up to 36 months after the date of your death.

Such a qualifying event, however, will not act to extend coverage beyond the original 18-month period under section A, or the date of your death under section B, for any dependents (other than a newborn or newly adopted child) who were added after the date continued coverage began.

E. Notice Requirements

If coverage for you or your dependents:

- is being continued for 18 months in accordance with section A; and
- it is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event in section A which would have caused coverage to terminate;

you or your dependent must notify your Employer of such determination within 60 days after the date of the determination, and within 30 days after the date of any final determination that you or your dependent is no longer disabled.

If coverage for a dependent would terminate due to:

- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated; or
- the dependent's ceasing to be a dependent child as defined under this Plan;

you or your dependent must provide notice to your Employer of the occurrence of the event. This notice must be given within 60 days after the later of the occurrence of the event and the date coverage would terminate due to the occurrence of the event.

If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

F. Other Continuation Provisions Under This Plan

If this Plan contains any other continuation provisions which apply when health expense coverage would otherwise terminate, contact your Employer for a description of how the federal and other continuation provisions interact under this Plan.

G. Conversion

If any coverage being continued under this section terminates because the end of the maximum period of continuation has been reached, any Conversion Privilege will be available at the end of such period on the same terms as are applicable upon termination of employment or upon ceasing to be in an eligible class.

Complete details of the federal continuation provisions may be obtained from your Employer.

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 will 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.

External Review

An "External Review" is a review by an independent physician with appropriate expertise in the area at issue, of claim denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment.

You may, at your option, obtain External Review of a claim denial provided that:

- You have exhausted the Aetna Life Insurance Company appeal process for denied claims, as outlined in the [Claim Procedures] section of this [Booklet], and you have received a final denial;
- The final denial was based upon a lack of medical necessity, or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue exceeds $500.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an External Review at the time the final decision on your internal appeal has been rendered. Either you or an individual acting on your behalf will be required to submit to Aetna Life Insurance Company the External Review Request Form (except under expedited review as described below), a copy of the Plan denial of coverage letter, and all other information you wish to be reviewed in support of your request. Your request for an External Review must be submitted, in writing, to Aetna Life Insurance Company within 60 calendar days after you receive the final decision on your internal appeal.

Aetna Life Insurance Company will contact the "External Review Organization" that will conduct your External Review. The External Review Organization will then select an independent physician with appropriate expertise in the area at issue for the purpose of performing the External Review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the External Review Request Form, and must follow the applicable plan's contractual documents and plan criteria governing the benefits.

The External Review Organization will generally notify you of the decision within 30 calendar days of Aetna Life Insurance Company's receipt of a properly completed External Review Form. The notice will state whether the prior determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer will be binding on the Plan, except where Aetna Life Insurance Company or the Plan can show reviewer conflict of interest, bias, or fraud. In such cases, notice will be given to you and the matter will be promptly resubmitted for consideration by a different reviewer.

An expedited review is available when your treating physician certifies on a separate Request For Expedited External Review form (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30 calendar day period) in receipt of the service or treatment would jeopardize your health. Expedited reviews will be decided within 5 calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna Life Insurance Company. Aetna Life Insurance Company is responsible for the cost of sending this information to the External Review Organization. The professional fee for the External Review will be paid by Aetna U.S. Healthcare.

In order for an individual to act on your behalf in connection with an External Review, you will need to specifically consent to the representation by signing the appropriate line on the External Review Request Form.

You may obtain more information about the External Review process by calling the toll-free Member Services telephone number listed on your ID card.

Table of Contents

The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the Customer.

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Health Expense Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Prescription Drug Expense Coverage

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all **prescription drugs**. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

Covered Prescription Drug Expenses

This Plan pays the benefits shown below for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by a **pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **pharmacy's** charge for the drug is more than the **copay** per **prescription** or refill.

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by a **preferred pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the **preferred pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf.

The Benefit Amount for each covered **prescription drug** or refill dispensed by a **non-preferred pharmacy** will be an amount equal to the Payment Percentage of the **non-preferred pharmacy's** charge for the drug except for an **emergency condition**, in which case the benefit will be payable at the preferred level of coverage.

Limitations

No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 30 day supply of any drug dispensed by a **mail order pharmacy**.
- For more than a 30 day supply per **prescription** or refill. However, this limitation does not apply to a supply of up to 90 days per **prescription** or refill for drugs which are provided by a **mail order pharmacy**.
- For the administration or injection of any drug.
- For the following injectable drugs:

  allergy sera or extracts; and

  Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year.
- For any refill of a drug if it is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:

  if the **prescriber** has not specified the number of refills; or

  if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by your Employer.
- For any **prescription drug** also obtainable without a **prescription** on an "over the counter" basis.
- For immunization agents.
- For biological sera and blood products.
- For nutritional supplements.
- For any smoking cessation aids or drugs.
- For appetite suppressants.
- For a **prescription drug** dispensed by a **mail order pharmacy** that is not a **preferred pharmacy**.

Comprehensive Medical Expense Coverage

Comprehensive Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Medical Expenses described below.

Covered Medical Expenses

They are the expenses for certain **hospital** and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

Hospital Expenses

Inpatient Hospital Expenses

Charges made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.

Outpatient Hospital Expenses

Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

Convalescent Facility Expenses

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury. The confinement must start during a "Convalescent Period".

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physician's** services.
- Medical supplies.

Benefits will be paid for up to the maximum number of days during any one Calendar Year. This starts on the first day a person is confined in a **convalescent facility** if he or she:

- was confined in a **hospital** for at least 3 days in a row, while covered under this Plan, for treatment of a disease or injury; and
- is confined in the facility within 14 days after discharge from the **hospital**; and
- is confined in the facility for services needed to convalesce from the condition that caused the **hospital** stay. These include skilled nursing and physical restorative services.

Limitations To Convalescent Facility Expenses
This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

Home Health Care Expenses

Home health care expenses are covered if:

- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or **convalescent facility**:

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  lab services provided by or for a **home health care agency**.

There is a maximum to the number of visits covered in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Health Care Expenses
This section does not cover charges made 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 wife's or husband's family.
- Services of a social worker.
- Transportation.

Hospice Care Expenses

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses
The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**;
- **convalescent facility**;

which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:

  pain control; and

  other acute and chronic symptom management.
- Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses

Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:

  assessment of the person's:

  social, emotional, and medical needs; and

  the home and family situation;

  identification of the community resources which are available to the person; and

  assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a **physician**.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.

Charges made by the providers below, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:

  physical and occupational therapy;

  part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  psychological and dietary counseling.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Contraception Expenses

Covered Medical Expenses include:

- charges incurred for contraceptive drugs and contraceptive devices that by law need a physician's prescription; and that have been approved by the FDA.
- related outpatient contraceptive services such as:

  consultations;
  exams;
  procedures; and
  other medical services and supplies.

Not covered are:

- charges for services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer; and
- charges incurred for contraceptive services while confined as an inpatient.

Infertility Services Expenses

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for infertility if all of the following tests are met:

- There exists a condition that:

  is a demonstrated cause of infertility; and

  has been recognized by a gynecologist or infertility specialist; and

  is not caused by voluntary sterilization or a hysterectomy;

  or

  For a female who is:

  under age 35, she has not been able to conceive after one year or more without contraception or 12 cycles of artificial insemination; or

  age 35 or older, she has not been able to conceive after six months without contraception or 6 cycles of artificial insemination.
- The procedures are performed while not confined in a **hospital** or any other facility as an inpatient.
- FSH levels are less than or equal to 19 miU on day 3 of the menstrual cycle.

- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

The following infertility services expenses will be Covered Medical Expenses:

- Ovulation induction with ovulatory stimulant drugs, subject to a maximum of 6 courses of treatment in a covered person's lifetime.
- Artificial insemination, subject to a maximum of 6 courses of treatment in a covered person's lifetime.

These expenses will be covered on the same basis as for disease.

A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.

In figuring the above Lifetime Maximums, Aetna will take into consideration, whether past or present, services received while covered, under a plan of benefits offered by Aetna; or one of its affiliated companies.

Not covered are charges for:

- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Cryopreservation or storage of cryopreserved embryos.
- Gestational carrier programs.
- Home ovulation prediction kits.
- In vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection.
- Frozen embryo transfers, including thawing.

Routine Physical Exams

The charges made by a **physician** for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. If charges made by a **physician** in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included as a part of the exam are:

- X-rays, lab, and other tests given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For your dependent child:

- The physical exam must include at least:

  a review and written record of the patient's complete medical history;

  a check of all body systems; and

  a review and discussion of the exam results with the patient or with the parent or guardian.
- For all exams given to your dependent child under age 2, Covered Medical Expenses will not include charges for:

  more than 6 exams performed during the first year of the child's life;

more than 2 exams performed during the second year of the child's life.

- For all exams given to your dependent child age 2 up to age 18, Covered Medical Expenses will not include charges for more than one exam in 12 months in a row.
- For all exams given to your dependent child age 18 and over, Covered Medical Expenses will not include charges for more than one exam in 24 months in a row.

For all exams given to you and your spouse, Covered Medical Expenses will not include charges for more than:

- one exam in 24 months in a row, if the person is under age 65; and
- one exam in 12 months in a row, if the person is age 65 or over.

Also included as Covered Medical Expenses are charges made by a **physician** for one annual routine gynecological exam.

Not covered are charges for:

- Services which are covered to any extent under any other group plan of your Employer.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a **hospital** or other facility for medical care.
- Services which are not given by a **physician** or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Vision, hearing, or dental exams.
- A **physician's** office visit in connection with immunizations or testing for tuberculosis.

Vision Care Services Expense Benefits

Covered Medical Expenses include charges for any service shown below which is furnished by a legally qualified ophthalmologist or optometrist to a person.

Routine Eye Exam Expenses

Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.

Covered Medical Expenses will not include charges for more than one routine eye exam for any period of 12 months in a row.

Limitations

The following limitations apply.

No benefits will be payable for a charge which is:

- For any eye exam to diagnose or treat a disease or injury.
- For drugs or medicines.
- For a vision care service that is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer.
- For a vision care service for which a benefit is provided in whole or in part under any workers' compensation law or any other law of like purpose.
- For special procedures. This means things such as orthoptics or vision training.
- For any vision care supply.

- For an eye exam which:

  is required by an employer as a condition of employment; or

  an employer is required to provide under a labor agreement; or

  is required by any law of a government.

- For a service received while the person is not covered.
- For a service or supply which does not meet professionally accepted standards.
- For any exams given while the person is confined in a **hospital** or other facility for medical care.
- For an eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses

Routine Hearing Exam Expenses

Covered Medical Expenses include charges for an audiometric exam. The services must be performed by: a Physician certified as an otolaryngologist or otologist; or

an audiologist who either:

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

who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Covered Medical Expenses will not include charges for more than one hearing exam for any period of 24 months in a row.

Benefits for the Routine Hearing Exam are subject to the applicable deductible or copay and payment percentage shown in the Summary of Coverage.

Limitations

Not included are charges for:

- any ear or hearing exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- any hearing care service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a **hospital** or other facility for medical care;
- any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government.

Other Medical Expenses

- Charges made by a **physician.**
- Charges made by a **R.N.** or **L.P.N.** or a nursing agency for skilled nursing care.

  As used here, "skilled nursing care" means these services:

  Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.

  Private duty nursing by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

  Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

  Not included as "skilled nursing care" is:

  that part or all of any nursing care that does not require the education, training, and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs, and companionship activities; or

  any private duty nursing care given while the person is an inpatient in a **hospital** or other health care facility; or

  care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or

  care provided solely for skilled observation except as follows:

  for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:

  change in patient medication;

  need for treatment of an **emergency condition** by a **physician** or the onset of symptoms indicating the likely need for such treatment;

  surgery; or

  release from inpatient confinement; or

  any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

- Charges for the following:

  Drugs and medicines which by law need a **physician's** prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.

  Diagnostic lab work and X-rays.

  X-ray, radium, and radioactive isotope therapy.

  Anesthetics and oxygen.

Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

Repair of purchased equipment.

Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.

Artificial limbs and eyes. Not included are such things as:

eyeglasses;

vision aids;

hearing aids;

communication aids; and

orthopedic shoes, foot orthotics, or other devices to support the feet.

National Medical Excellence Program ® (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

Travel Expenses

These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses
These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum
For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:

  one year after the day the procedure is performed; and

  the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Limitations
Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

Healthy Outlook Program

This is a disease management program for covered persons with one or more of the following chronic conditions:

- asthma;
- congestive heart failure;
- coronary artery disease;
- diabetes; and
- low back pain.

A "participant" in this program is a covered person:

- who has identified himself or herself; or
- who has been identified by:

  his or her attending physician or other health care provider; or

  Aetna; or

  his or her Employer; and
- who is approved by Aetna as a participant.

Any visit or day calendar year maximum, or visit or day lifetime maximum under this Plan will not be reduced. However, any dollar calendar year maximum or dollar lifetime maximum under this Plan will be reduced. Any applicable deductible will be waived.

Explanation of Some Important Plan Provisions

Inpatient Hospital Deductible

This is the amount of Inpatient Hospital Expenses you pay for each **hospital** confinement of a person.

The Inpatient Hospital Deductible will only be applied once to all **hospital** confinements, regardless of cause, which are separated by less than 10 days.

Expenses used to meet the Inpatient Hospital Deductible cannot be used to meet any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Inpatient Hospital Deductible.

Calendar Year Deductible

This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

Family Deductible Limit

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Hospital Emergency Room Deductible and Hospital Emergency Room Copay

A separate Hospital Emergency Room Deductible or Copay applies to each visit for **emergency care**, by a person to a **hospital's** emergency room, unless the person is admitted to the **hospital** as an inpatient immediately following a visit to a **hospital** emergency room.

Limitations

Preexisting Conditions

A "preexisting condition" is an injury or disease for which a person:

- received treatment or services; or
- took prescribed drugs or medicines;

during the 180 days right before the person's effective date of coverage (or, if the Plan requires you to serve a probationary period, the 180 days right before the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Summary of Coverage, whichever applies, to determine a person's effective date of coverage.

For the first 365 days following such date, Covered Medical Expenses do not include any expenses for treatment of a preexisting condition.

Special Rules As To A Preexisting Condition

If a person had creditable coverage and such coverage terminated within 90 days prior to the date he or she enrolled (or was enrolled) in this Plan, then any limitation as to a preexisting condition under this Plan will not apply for that person.

Also, if a person enrolls (or is enrolled) in this Plan immediately after any applicable probationary period has been served, and that person had creditable coverage which terminated within 90 days prior to the first day of such probationary period, then any limitation as to a preexisting condition will not apply for that person.

As used above: "creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

Routine Mammogram

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred by a female age 40 or over for one mammogram each calendar year.

Mouth, Jaws, and Teeth

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, **physician** includes a **dentist**.

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out:

  teeth 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.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

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

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the calendar year of the accident or the next one.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only 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.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for routine tooth removal (not needing cutting of bone).

Not included are charges:

- to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, in-mouth scaling, planing or scraping;
- for myofunctional therapy; this is:

  muscle training therapy; or

  training to correct or control harmful habits.

Non-Emergency Care In An Emergency Room

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Reduced Payment Percentage.

No benefit will be paid under any other part of this Plan for charges made by a **hospital** for care in an emergency room that is not **emergency care**.

Certification For Hospital Admissions

This certification section applies to admissions other than those for the treatment of alcoholism, drug abuse or **mental disorders**. A separate section applies to such admissions.

If:

- a person becomes confined in a **hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by a **physician** who is a **Preferred Care Provider**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:

  If certification has been requested and denied:

  No benefits will be paid for Hospital Expenses incurred for board and room.

  Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

  No benefits will be paid for Hospital Expenses incurred for board and room.

  As to all other Hospital Expenses:

  Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:

  Hospital Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other Hospital Expenses will be payable at the Payment Percentage.
- As to other Covered Medical Expenses:

  Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied to expenses for **hospital** room and board.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission;** or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician**, or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

Certification For Convalescent Facility Admissions, Home Health Care Expenses, Hospice Care Expenses, and Skilled Nursing Care

If a person incurs Covered Medical Expenses:

- while confined in a **convalescent facility** or a **hospice facility**; or
- for a service or a supply for home health care or hospice care while not confined as an inpatient or skilled nursing care; and

it has not been certified that:

- such confinement or any day of it is **necessary**; or
- such other services or supplies (either specifically or as a part of a planned program of care) are **necessary**, and
- the confinement or service or supply has not been ordered or prescribed by a **physician** who is a **Preferred Care Provider**;

such Covered Medical Expenses will be paid only as follows:

- As to Convalescent Facility Expenses and Hospice Care Facility Expenses incurred while confined in a **convalescent facility** or a **hospice facility**:

  If certification has been requested and denied:

  No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

  Benefits for all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

  No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

  As to all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:

  Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses. Benefits for all other such expenses will be paid at the Payment Percentage.

  If certification has not been requested and the confinement or (any day of such confinement) is **necessary**:

  Convalescent Facility Expenses or Hospice Care Facility Expenses, incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other such expenses, incurred during the confinement, will be paid at the Payment Percentage.

As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.

- As to Covered Medical Expenses incurred for services or supplies either as stated or as a part of a planned program of care for home health care, hospice care while not confined as an inpatient, or skilled nursing care:

  If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not **necessary**, no benefits will be paid for the denied or unnecessary service or supply.

  If certification has not been requested for a service or supply and the service or supply is **necessary**, benefits for the necessary service or supply will be paid as follows:

  Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan; except that:

- To the extent that a day of confinement has been certified, the exclusion of services and supplies because they are not **necessary** will not apply to:

  Convalescent Facility Expenses for room and board; or

  Hospice Care Facility Expenses for room and board.
- To the extent that such service or supply has been certified for home health care, hospice care, or skilled nursing care, the exclusion of services or supplies because they are not **necessary** will not apply to such service or supply.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies.

Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If:

- services and supplies for hospice care provided to a person have been certified; and
- the person later requires confinement in a **hospital** for pain control or acute symptom management;

any other certification requirement in this plan will be waived for any such day of confinement in a **hospital**.

Certification For Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse or Mental Disorders

If, in connection with the **effective treatment of alcoholism or drug abuse** or treatment of **mental disorders**, a person incurs Covered Medical Expenses while confined in a **hospital** or **treatment facility**; and

- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by a **physician** who is a **Preferred Care Provider:**

Covered Medical Expenses incurred on any day not certified during the confinement will be paid only as follows:

With respect to expenses for **hospital** and **treatment facility** board and room:

If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not **necessary**, no benefits will be paid.

If certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

With respect to all other **hospital** and **treatment facility** expenses:

If certification has been requested and denied, or if certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement is not **necessary**, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not **necessary** will not be applied to **hospital** and **treatment facility** board and room.

To get the days certified, you must call the number shown on your ID card. Such certification must be obtained before confinement as a full-time inpatient, or in the case of an **emergency admission**, within 48 hours after the start of a confinement as a full-time inpatient or as soon as reasonably possible.

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

Treatment of Alcoholism, Drug Abuse, or Mental Disorders

Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment

If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Hospital

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Effective treatment of alcoholism or drug abuse.**
- Treatment of **mental disorders**.

Treatment Facility

Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Other **necessary** services and supplies.

Calendar Year Maximum Benefit

A Special Inpatient Calendar Year Maximum Days applies to the **hospital** and **treatment facility** expenses described above.

Outpatient Treatment

If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital**, **treatment facility** or **physician**, benefits will not be payable for more than the Special Outpatient Calendar Year Maximum Visits in any one calendar year.

General Exclusions

General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be 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 disease or injury involved; or

  if required by the FDA, approval has not been granted for marketing; or

  a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; 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, investigational, or for research purposes.

  However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

  the disease can be expected to cause death within one year, in the absence of effective treatment; and

  the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

  Also, this exclusion will not apply with respect to drugs that:

  have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

  are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

  if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.
- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.

- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.
- Those for services and supplies:

  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

  Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)
- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:

  sildenafil citrate;
  phentolamine;
  apomorphine;
  alprostadil; or
  any other drug that

  is in a similar or identical class,
  has a similar or identical mode of action or exhibits similar or identical outcomes.

  This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in your Booklet.

- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

  Improve the function of a part of the body that:

  is not a tooth or structure that supports the teeth; and

  is malformed:

  as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or

  as a direct result of:

  disease; or

  surgery performed to treat a disease or injury.

  Repair an injury. Surgery must be performed:

  in the calendar year of the accident which causes the injury; or

  in the next calendar year.
- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for the reversal of a sterilization procedure.
- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a calendar year, this Plan will pay:

- its regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract B. from A. below:

  A. 100% of "Allowable Expenses" incurred by the person for whom claim is made.
  B. The benefits payable by the "other plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any **necessary** and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made.

The difference between the cost of a private **hospital** room and the **semiprivate rate** is not considered an Allowable Expense under the above definition unless the patient's stay in a private **hospital** room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

      If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

   If the other plan does not have a provision:

   - regarding laid-off or retired employees; and

- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

Aetna has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

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

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an Eligible Class and have chosen coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Health Expense Coverage (except Vision Care, if any) on the date of your coverage under such HMO Plan.

If you are in an Eligible Class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this Plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the first day of the contract period which follows the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when Aetna gives its written consent.

- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when the Aetna gives its written consent.

Any extensions of benefits under this Plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this Plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- the end of a 90 day period; and
- the date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

Effect of Prior Coverage - Transferred Business

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next service fee due date following the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 30 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer, but not beyond the end of the calendar month after the calendar month in which the absence started.

The Summary of Coverage may show an Eligible Class of retired employees. If you are in that class, your employment may be deemed to continue:

- for any coverage shown in the Retirement Eligibility section; and
- subject to any limits shown in that section.

If no Eligible Class of retired employees is shown, there is no coverage for retired employees.

If you cease active work, ask your Employer if any coverage can be continued.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under this Plan.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

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 a personal 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; and
- he or she depends chiefly on you for support and maintenance.

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

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.

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.

Health Expense Benefits After Termination

If a person is totally disabled when his or her Health Expense Coverage ceases, benefits will be available to such person while he or she continues to be totally disabled for up to the applicable period shown below.

The words "totally disabled" mean that due to injury or disease:

- You are not able to engage in your customary occupation and are not working for pay or profit.
- Your dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

Medical Expense benefits will be available to him or her while disabled for up to 12 months.

Health Expense benefits will cease when the person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.)

If this provision applies to you or one of your covered dependents, see the section Conversion of Medical Expense Coverage for information which may affect you.

Conversion of Medical Expense Coverage

This Plan permits certain persons whose Medical Expense Coverage has ceased to convert to a personal medical policy. No medical exam is needed. You and your family members may convert when all coverage ceases because your employment ceases or you cease to be in an eligible class. You may not convert if coverage ceases because the group contract has discontinued as to your medical coverage.

The personal policy may cover:

- you only; or
- you and all of your family members who are covered under this Plan when your coverage ceases; or
- if you die before you retire, all your family members, or your spouse only, who are covered under this Plan when your coverage ceases.

Also, if your own coverage continues, your dependents can apply if they cease to be a dependent as defined in this Plan.

You may convert when you become a retired employee. If this Plan permits retired employees to continue Medical Expense Coverage, and you choose to do so, this conversion privilege will not again be available to you.

The personal policy must be applied for within 31 days after coverage ceases or would otherwise cease without a provision to continue coverage for retired employees. The 31 days start on the date coverage actually ceases even if the person is still eligible for benefits because the person is totally disabled.

Aetna may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:

  any other hospital or surgical expense insurance policy;

  any hospital service or medical expense indemnity corporation subscriber contract;

  any other group contract;

  any statute, welfare plan or program;

  and that with the converted policy, would result in overinsurance or match benefits.

No one has the right to convert if you have been covered under this Plan for less than 3 months. Also, no person has the right to convert if:

- he or she has used up the maximum benefit; or
- he or she becomes eligible for any other Medical Expense Coverage under this Plan.

The personal policy form, and its terms, will be of a type, for group conversion purposes:

- as required by law or regulation; or
- as then offered by Aetna under your Employer's conversion plan.

It will not provide coverage which is the same as coverage under this Plan. The level of coverage may be less and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both of:

- A statement that benefits under it will be cut back by any like benefits payable under this Plan after your coverage ceases.
- A statement that Aetna may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.

The personal policy will state that Aetna has the right to refuse renewal under some conditions. These will be shown in that policy.

If you or your dependent want to convert:

- Your Employer should be asked for a copy of the "Notice of Conversion Privilege and Request" form.
- Send the completed form to the address shown.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply.

The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be Aetna's normal rate for the person's class and age, and the form and amount of coverage.

The personal policy will take effect on the day after coverage terminates under this Plan.

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

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

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the Plan Document on file with your Employer. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued as to all or any class of employees.

Assignments

Coverage may be assigned only with the written consent of Aetna.

Recovery of Benefits Paid

As a condition to payment of benefits under this Plan for expenses incurred by a covered person due to injury or illness for which a third party may be liable:

- The Plan shall, to the extent of benefits it has paid, be subrogated to (has the right to pursue) all rights of recovery of covered persons against:

  such third party; or

  a person's insurance carrier in the event of a claim under the uninsured or underinsured auto coverage provision of an auto insurance policy.
- The Plan shall have the right to recover from the covered person amounts received by judgment, settlement, or otherwise from:

  such third party or his or her insurance carrier; or

  any other person or entity, which includes the auto insurance carrier which provides the covered person's uninsured or underinsured auto insurance coverage.
- The covered person (or person authorized by law to represent the covered person if he or she is not legally capable) shall:

  execute and deliver any documents that are required; and

  do whatever else is necessary to secure such rights.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; 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 this 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 for any benefits is 90 days after the date of the loss causing the claim.

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 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. For all benefits except any Temporary Disability Benefit, written proof must be provided.

All benefits are payable to you. However, this Plan 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.

This Plan may pay up to $ 1,000 of any 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. It can also be done if a benefit is payable to your estate.

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.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Board and Room Charges

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

Brand Name Drug

A **prescription drug** which is protected by trademark registration

Companion

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

  professional nursing care by a **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 **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.
- Makes charges.

Copay

This is a fee, charged to a person, which represents a portion of the applicable expense. It is specified in the Summary of Coverage.

As to a **prescription drug** dispensed by a **preferred pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is dispensed

As to a **prescription drug** dispensed by a **non-preferred pharmacy**, this is the amount by which the total charge for the **prescription drug** is reduced before benefits are payable.

For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed. In no event will the copay be greater than the prescription, kit, or refill.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory

This is a listing of all **Preferred Care Providers** for the class of employees of which you are a member. Copies of this Directory are given to your Employer to give to you. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at www.aetna.com.

Durable Medical and Surgical Equipment

This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Effective Treatment of Alcoholism Or Drug Abuse

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Emergency Admission

One where the **physician** admits the person to the **hospital** or **treatment facility** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:

  placing the person's 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.

Emergency Care

This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, 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, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's 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.

Emergency Condition

This means 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, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's 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.

Generic Drug

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home Health Care Agency

This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or a **R.N.**; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan

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

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

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

This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:

  skilled nursing services; and

  medical social services; and

  psychological and dietary counseling.
- Provides or arranges for other services which will include:

  services of a **physician**; and

  physical and occupational therapy; and

  part-time home health aide services which mainly consist of caring for **terminally ill** persons; and

  inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:

  one **physician**; and

  one **R.N.**; and

  one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- 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.
- Utilizes 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.
- 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

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- 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 such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a **R.N.**
- Has a full-time administrator.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N.

This means a licensed practical nurse.

Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail.

Medication Formulary

A listing of **prescription drugs** which have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both **brand name drugs** and **generic drugs** and is subject to periodic review and modification by Aetna. See your Employer for a current listing.

Mental Disorder

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

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

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

NME Patient

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;

- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

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

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge

This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease 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 disease under such law.

Non-Occupational Injury

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

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

Non-Preferred Care

This is a health care service or supply furnished by a health care provider that is not a **Preferred Care Provider**; if, as determined by Aetna:

- the service or supply could have been provided by a **Preferred Care Provider**; and
- the provider is of a type that falls into one or more of the categories of providers listed in the **Directory**.

Non-Preferred Care Provider

This is:

- a health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**; or
- a **Preferred Care Provider** that is furnishing services or supplies without the referral of a **Primary Care Physician**.

Non-Preferred Pharmacy
A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

Non-Specialist
A **physician** who is not a **specialist**.

Non-urgent Admission
One which is not an **emergency admission** or an **urgent admission**.

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.

Not included is:

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

Other Health Care
This is a health care service or supply that is neither **Preferred Care** nor **Non-Preferred Care**.

Pharmacy
An establishment where **prescription drugs** are legally dispensed.

Physician
This means a legally qualified physician.

Preferred Care
This is a health care service or supply furnished by:

- a **Preferred Care Provider**; or
- a health care provider that is not a **Preferred Care Provider** for an **emergency condition** when travel to a **Preferred Care Provider** is not feasible.

Preferred Care Provider
This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

Preferred Pharmacy

A **pharmacy,** including a **mail order pharmacy,** which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

Prescriber

Any person, while 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 of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

Prescription Drugs

Any of the following:

- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

R.N.

This means a registered nurse.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The reasonable 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; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

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

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the 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 prevailing charge in other 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 reasonable charge is the rate established in such agreement.

Semiprivate Rate

This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Specialist

A **physician** who:

practices in any generally accepted medical or surgical sub-specialty; and
is providing other than routine medical care.

A **physician** who:

practices in such a sub-specialty; and
is providing routine medical care (such as could be given by a **primary care physician**),

will not be considered a Specialist for purposes of applying this plan's **copay** provisions.

Terminally Ill

This is a medical prognosis of 6 months or less to live.

Treatment Facility (Alcoholism Or Drug Abuse)

This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **effective treatment of alcoholism or drug abuse.**
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician.**
- Provides, on the premises, 24 hours a day:

  Detoxification services needed with its effective treatment program.

  Infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.

  Supervision by a staff of **physicians.**

  Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

Urgent Admission

One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, 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.

Continuation of Coverage under Federal Law

The terms of this continuation of coverage provision do not apply to the Plan of any Employer that employs fewer than 20 employees, in accordance with a formula mandated by federal law. Check with your Employer to determine if this continuation of coverage provision applies to this Plan.

In accordance with federal law (PL 99-272) as amended, your Employer is providing covered persons with the right to continue their health expense coverage under certain circumstances.

You or your dependents may continue any health expense coverage then in effect, if coverage would terminate for the reasons specified in sections A, B, or C below. You and your dependents may be required to pay up to 102% of the full cost to the Plan of this continued coverage, or, as to a disabled individual whose coverage is being continued for 29 months in accordance with section A, up to 150% of the full cost to the Plan of this continued coverage for any month after the 18th month.

Subject to the payment of any required contribution, health expense coverage may also be provided for any dependents you acquire while the coverage is being continued. Coverage for these dependents will be subject to the terms of this Plan regarding the addition of new dependents.

Continuation shall be available as follows:

A. Continuation of Coverage on Termination of Employment or Loss of Eligibility

If your coverage would terminate due to:

- termination of your employment for any reason other than gross misconduct; or
- your loss of eligibility under this Plan due to a reduction in the number of hours you work;

you may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue his or her own coverage. This election must include an agreement to pay any required contribution. You or your dependents must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs you or your eligible dependents of any rights under this section.

Coverage will terminate on whichever of the following is the earliest to occur:

- The end of an 18-month period after the date of the event which would have caused coverage to terminate.
- The end of a 29-month period after the date of the event which would have caused coverage to terminate, but only if prior to the end of the above 18-month period, you or your dependent provides notice to your Employer, in accordance with section E below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event which would have caused coverage to terminate. Coverage may be continued: for the individual determined to be disabled; and for any family member (employee or dependent) of the disabled individual, for whom coverage is already being continued; and for your newborn or newly adopted child who was added after the date continued coverage began.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.

- The first day after the date of the election that the individual becomes covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the individual becomes enrolled in benefits under Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.
- As to all individuals whose coverage is being continued in accordance with the terms of the second bulleted item above, the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled individual whose coverage is being so continued is no longer disabled; but in no event shall coverage terminate prior to the end of the 18-month period described in the first bulleted item above.

B. Continuation of Coverage on a Retiree's Loss of Coverage

The Plan Administrator is required to notify a retired employee if his or her former Employer commences a bankruptcy proceeding under Title 11, United States Code. If your coverage as a retired employee would terminate or be substantially eliminated due to this proceeding (or within the 12-month period prior to or following such proceeding), you may be eligible to elect to continue coverage for yourself and your dependents or your dependents may each be eligible to elect to continue his or her own coverage. If you are determined to be eligible, you or your dependents must elect to continue coverage within 60 days of the later to occur of the date the bankruptcy proceedings begin and the date the Plan Administrator informs you or your eligible dependents of any rights under this section. The election must include an agreement to pay any required contribution.

Coverage under this section will terminate on the first to occur of:

- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that the individual becomes covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.

C. Continuation of Coverage Under Other Circumstances

If coverage for a dependent would terminate due to:

- your death;
- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated;
- the dependent's ceasing to be a dependent child as defined under this Plan; or
- the dependent's loss of eligibility under this Plan because you become entitled to benefits under Medicare;

the dependent may elect to continue his or her own coverage. The election to continue coverage must be made within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs your dependents, subject to any notice requirements in section E below, of their continuation rights under this section. The election must include an agreement to pay any required contribution.

Coverage for a dependent will terminate on the first to occur of:

- The end of a 36-month period after the date of the event which would have caused coverage to terminate.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to your dependents under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that the dependent becomes covered under another group health plan. However, continued coverage will not terminate until such time that the dependent is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

D. Multiple Qualifying Events

If coverage for you or your dependents is being continued in accordance with the terms of the above sections A or B, the following shall apply:

- If coverage is being continued for a period specified under section A, and during this period one of the qualifying events under the above section C occurs, this period may be increased. In no event will the total period of continuation provided under this provision for any dependent be more than 36 months.
- If coverage is being continued under section B, and if your death occurs during this continuation, your dependents may elect to continue their coverage for up to 36 months after the date of your death.

Such a qualifying event, however, will not act to extend coverage beyond the original 18-month period under section A, or the date of your death under section B, for any dependents (other than a newborn or newly adopted child) who were added after the date continued coverage began.

E. Notice Requirements

If coverage for you or your dependents:

- is being continued for 18 months in accordance with section A; and
- it is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event in section A which would have caused coverage to terminate;

you or your dependent must notify your Employer of such determination within 60 days after the date of the determination, and within 30 days after the date of any final determination that you or your dependent is no longer disabled.

If coverage for a dependent would terminate due to:

- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated; or
- the dependent's ceasing to be a dependent child as defined under this Plan;

you or your dependent must provide notice to your Employer of the occurrence of the event. This notice must be given within 60 days after the later of the occurrence of the event and the date coverage would terminate due to the occurrence of the event.

If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

F. Other Continuation Provisions Under This Plan

If this Plan contains any other continuation provisions which apply when health expense coverage would otherwise terminate, contact your Employer for a description of how the federal and other continuation provisions interact under this Plan.

G. Conversion

If any coverage being continued under this section terminates because the end of the maximum period of continuation has been reached, any Conversion Privilege will be available at the end of such period on the same terms as are applicable upon termination of employment or upon ceasing to be in an eligible class.

Complete details of the federal continuation provisions may be obtained from your Employer.

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 will 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.

External Review

An "External Review" is a review by an independent physician with appropriate expertise in the area at issue, of claim denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment.

You may, at your option, obtain External Review of a claim denial provided that:

- You have exhausted the Aetna Life Insurance Company appeal process for denied claims, as outlined in the [Claim Procedures] section of this [Booklet], and you have received a final denial;
- The final denial was based upon a lack of medical necessity, or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue exceeds $500.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an External Review at the time the final decision on your internal appeal has been rendered. Either you or an individual acting on your behalf will be required to submit to Aetna Life Insurance Company the External Review Request Form (except under expedited review as described below), a copy of the Plan denial of coverage letter, and all other information you wish to be reviewed in support of your request. Your request for an External Review must be submitted, in writing, to Aetna Life Insurance Company within 60 calendar days after you receive the final decision on your internal appeal.

Aetna Life Insurance Company will contact the "External Review Organization" that will conduct your External Review. The External Review Organization will then select an independent physician with appropriate expertise in the area at issue for the purpose of performing the External Review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the External Review Request Form, and must follow the applicable plan's contractual documents and plan criteria governing the benefits.

The External Review Organization will generally notify you of the decision within 30 calendar days of Aetna Life Insurance Company's receipt of a properly completed External Review Form. The notice will state whether the prior determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer will be binding on the Plan, except where Aetna Life Insurance Company or the Plan can show reviewer conflict of interest, bias, or fraud. In such cases, notice will be given to you and the matter will be promptly resubmitted for consideration by a different reviewer.

An expedited review is available when your treating physician certifies on a separate Request For Expedited External Review form (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30 calendar day period) in receipt of the service or treatment would jeopardize your health. Expedited reviews will be decided within 5 calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna Life Insurance Company. Aetna Life Insurance Company is responsible for the cost of sending this information to the External Review Organization. The professional fee for the External Review will be paid by Aetna U.S. Healthcare.

In order for an individual to act on your behalf in connection with an External Review, you will need to specifically consent to the representation by signing the appropriate line on the External Review Request Form.

You may obtain more information about the External Review process by calling the toll-free Member Services telephone number listed on your ID card.

Summary Plan Description

Lee County BoCC

Aetna Choice™ POS Plan

Welcome!

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

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

Your benefits program is self-funded by Lee County BoCC and administered by Aetna Life Insurance Company (Aetna).

We wish you the best of health.

How to Use Your Summary Plan Description

This booklet is your guide to the benefits available through the Aetna Choice™ Point-of-Service (POS) Plan (the "Plan"). Please read it carefully and refer to it when you need information about how the Plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about many of the special programs available to you as a Plan participant.

If you cannot find the answer to your question(s) in the booklet, call the Member Services toll-free number on your ID card. A trained representative will be happy to help you. For more information, go to the "Member Services" section later in this book.

Tips for New Plan Participants

- Keep this handbook where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Post your Primary Care Physician's name and number near the phone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See "In Case of Medical Emergency" for emergency care guidelines.

Table of Contents

How the Plan Works

The Choice Is Yours

The Aetna Choice™ Point-of-Service (POS) Plan offers you the convenience and cost savings of a health maintenance organization (HMO)-type plan with the freedom and flexibility of a traditional medical plan. You have access to a network of Primary Care Physicians (PCPs), specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

Each participant in the Plan is encouraged to select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system, and will monitor your overall care.

As an Aetna Choice POS Plan participant, you have a choice each time you need medical care:

In-Network Care

When your PCP provides your care, or you receive care from a participating specialist or hospital, you receive the maximum benefits available under the Plan for covered services. After making a **copayment** for certain types of in-network care, you have no further out-of-pocket expenses, up to the limits shown in the "Summary of Benefits."

You don't have to meet a deductible for in-network care and there are no claim forms to fill out.

Out-of-Network Care

You can directly access doctors or hospitals of your choice outside of the Aetna Choice POS network. Your care is "out-of-network" if you don't obtain care from a provider in the network. The Plan covers out-of-network care, but your expenses will be higher:

- You must satisfy an annual **deductible** before the Plan begins to pay benefits.
  Note: Covered expenses that you incur in the last three months of the calendar year that apply toward your deductible for that calendar year are also applied toward your deductible for the following calendar year. This is called "deductible carryover."
- Once you've met the deductible, you must pay a portion of the covered out-of-network expenses you incur (your **out-of-network coinsurance** share), up to the **out-of-network out-of-pocket maximum**. The out-of-network out-of-pocket maximum controls your annual out-of-network expenses. Your deductible does not apply toward the out-of-network out-of-pocket maximum.

- If the provider you select charges more than the reasonable and customary expense determined by Aetna, you must pay any expenses above reasonable and customary. That excess amount does not apply toward your out-of-pocket maximum.
- Certain types of medical care require precertification. When you receive care outside of the network, you are responsible for obtaining the necessary precertification. If you don't, your benefits will be significantly reduced.

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. He or she can provide primary care, as well as keep track of your overall care.

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

Primary and Preventive Care

Your selected PCP can provide preventive care and treat you for illnesses and injuries. The Plan includes coverage for routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP. You are only subject to the PCP copay when accessing care from your selected PCP. Please note that care received from any other network physician is subject to the specialist copay.

Coverage for out-of-network primary and preventive care is limited. Refer to the "Summary of Benefits" for details.

Specialty and Facility Care

In-Network

The Aetna Choice POS plan provides you with the freedom to choose any participating provider for medically necessary services. When accessing any participating physician other than your selected PCP, the specialist copay will apply.

Out-of-Network

Receiving care within the network can minimize your out-of-pocket expenses and help you find appropriate care more quickly. The Plan offers you the option, however, of seeking care outside of the network. When your covered care is provided by doctors and facilities that are outside of the network, you will be subject to the out-of-network deductible, coinsurance and maximum benefits shown in the "Summary of Benefits." You must also obtain any necessary precertification, and you will probably have to file a claim form for reimbursement.

Precertification

You are covered for specialty care when you obtain care at participating specialists or facilities. If, however, you choose to access care outside of the network, you must obtain authorization prior to receiving the following out-of-network care:

Inpatient Hospital and Hospital Alternatives: • Home health services. • Hospice care – inpatient and outpatient. • Hospital admissions. • Private duty nursing. • Skilled nursing care – inpatient and outpatient. Behavioral Health: • Mental health services – inpatient. • Substance abuse services – inpatient and outpatient. Emergency services within 24 hours of emergency room admission or as soon as possible. Durable medical equipment and prosthetic devices – precertification required for equipment leased or purchased over $1,500.	Outpatient Therapy: • Cardiac rehabilitation – outpatient. • Cognitive therapy. • Occupational therapy – outpatient. • Physical therapy – outpatient. • Pulmonary rehabilitation – outpatient. • Respiratory therapy – outpatient. • Speech therapy – outpatient. Other Procedures, Treatments and Services (Inpatient or Outpatient): • Chiropractic care. • Infertility services. • Maternity care. • Organ transplants. • Outpatient surgery. • Reconstructive surgery.

How to Precertify

Call the Member Services telephone number on your ID card to request precertification at least 14 days before:

- A scheduled admission to a hospital, skilled nursing facility, or hospice care facility; or
- Any of the other procedures or treatments listed above.

You or your PCP must call Member Services within 24 hours after an emergency admission, or as soon thereafter as reasonably possible. If you are unable to call, a family member or friend can make the call on your behalf.

When you call Member Services to precertify medical care, a nurse consultant will ask for some information, including:

- The name of the patient;
- The condition being treated;
- The doctor's name, address and telephone number;
- The medical facility's name, address and telephone number; and
- The scheduled date for admission or delivery of services.

Confirmation of Precertification

The length of a hospital confinement is certified based on common practice and usual rates of recovery. For a hospital stay, you, your physician and the hospital will receive a letter verifying your certified length of stay (LOS). If your physician subsequently recommends a longer period of time in the hospital, you, your physician or the facility must call Member Services to certify the extra days. This must be done no later than the last day previously certified.

For a proposed procedure or other treatment, Aetna will send a written notice of the precertification decision to both you and the provider performing the procedure or treatment. The decision will be valid for 60 days from the date you receive the notice. If more than 60 days pass before the procedure or treatment is performed, you must request precertification again.

If You Don't Precertify

If you don't precertify as required, your benefits will be reduced by 50%.

You are responsible for expenses that are excluded because you did not obtain the required precertification. These penalties do not count toward your deductible or out-of-pocket maximum.

Provider Information

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

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

Your ID Card

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

Always carry your ID card with you. It identifies you as a Plan participant when you receive services from participating providers or when you receive emergency services. [When you obtain a prescription at a participating pharmacy, remember to present your ID card. If your card is lost or stolen, please notify Aetna immediately.

Summary of Benefits

Type of Service or Supply	In-Network Care Care provided by in-network providers	Out-of-Network Care Care from out-of-network providers
Calendar Year Deductible		
Individual	None	$500
Family	None	$1,000
Annual Out-of-Pocket Limit		
Individual	$1,500	$2,000
Family	$3,000	$4,000
Lifetime Maximum	None	$1,000,000
Primary and Preventive Care		
PCP Office Visits	$10 copay per visit	70% after deductible
After Hours/Home Visits/Emergency Visits	$15 copay per visit	70% after deductible
Routine Examinations	$10 copay per visit	Not covered
Routine Child and Well-Baby Care	$10 copay per visit	Not covered
Immunizations	$10 copay per visit	Not covered
Routine Gynecological Examinations	$25 copay per visit - one routine exam and Pap smear per 365-day period.	Not covered
Routine Mammogram (for women age 35-39, one baseline mammogram, for women age 40 and over, one annual mammogram)	$25 copay per visit	70% after deductible
Prostate Screening (one annual prostrate screening for men age 40 and over)	$25 copay per visit	70% after deductible
Routine Eye Exams	$25 copay per visit	Not covered
Eyeglasses/Contact Lenses	Discounts available through Vision One Discount Program.	Not covered
Routine Hearing Screenings	Covered when performed as part of a routine exam. Subject to office visit copay.	Not covered
Hearing Aids	Not covered	Not covered
Specialty and Outpatient Care		
Specialist Office Visits	$25 copay per visit	70% after deductible
Prenatal Care	$25 copay for the first OB visit	70% after deductible

Type of Service or Supply	In-Network Care Care provided by in-network providers	Out-of-Network Care Care from out-of-network providers
Infertility Services	$25 copay per visit	70% after deductible
Advanced Reproductive Technology	Not covered	Not covered
Allergy Testing	$25 copay per visit	70% after deductible
Allergy Treatment Routine injections at PCP's office, with or without physician	$10 copay	70% after deductible
X-rays and Lab Tests	$25 copay	70% after deductible
Therapy (speech, occupational, physical)	$25 copay per visit - 60 consecutive days per illness or injury	70% after deductible
Chiropractic Care	$25 copay per visit, 20 visits per year	70% after deductible, $1,000 calendar year maximum
Dermatologist	$25 copay per visit – up to 5 visits in a 12 month period	70% after deductible
Podiatrist	$25 copay per visit	70% after deductible
Home Health Care	No copay	70% after deductible - one visit per day, up to 4 hours per visit
Hospice Care	No copay	70% after deductible - $10,000 combined lifetime maximum for inpatient and outpatient care
Durable Medical Equipment	No copay - must be approved in advance by Aetna	70% after deductible
Prosthetic Devices	No copay - some prostheses must be approved in advance by Aetna	70% after deductible
Inpatient Services		
Hospital Room and Board and Other Inpatient Services	$250 copay per admission (waived if readmitted within 30 days)	70% after deductible
Skilled Nursing Facility	$250 copay per admission (waived if readmitted within 30 days)	70% after deductible - 240 days per calendar year, 35 physician visits.
Hospice Facility	$250 copay	70% after deductible - $10,000 combined lifetime maximum for inpatient and outpatient care

Type of Service or Supply	In-Network Care Care provided by in-network providers	Out-of-Network Care Care from out-of-network providers
Surgery and Anesthesia		
Inpatient Surgery	Subject to room and board copay	70% after deductible
Outpatient Surgery	$100 copay - outpatient facility $25 copay - specialist's office	70% after deductible
Mental and Nervous Conditions		
Inpatient Treatment Combined maximum of 30 days per year for in-network and out-of-network care."	$250 copay per admission	70% after deductible
Outpatient Treatment Combined maximum of 20 visits per year for in-network and out-of-network care	$25 copay per visit	50% after deductible
Partial Hospitalization	1 day of inpatient care may be exchanged for 2 partial hospitalization and/or electroshock sessions in lieu of hospitalization. Must be approved in advance by Aetna.	
Inpatient Benefit Exchange	1 day of inpatient treatment may be substituted for 4 outpatient visits or home health visits, up to a maximum of 10 inpatient days/40 outpatient visits.	
Substance Abuse		
Inpatient Detoxification	$250 copay per admission	70% after deductible
Inpatient Rehabilitation Combined maximum of 30 days per 365-day period for in-network and out-of-network care	$250 copay per admission	70% after deductible
Outpatient Detoxification	$25 copay per visit	70% after deductible
Outpatient Rehabilitation	$25 copay per visit – 30 visits per year	70% after deductible – 44 visits per year
Emergency Care/Urgent Care		
Emergency Room	$50 copay (waived if admitted)	$50 copay (waived if admitted)
Non-Emergency Use of the Emergency Room	Not covered	Not covered
Ambulance	No copay when medically necessary	No copay when medically necessary
Prescription Drugs	No annual maximum	Not covered
Retail (30-day supply)	$10 copay – generic formulary drugs $20 copay – brand-name formulary drugs $35 copay – non-formulary drugs	Not covered
Mail Order (up to a 90-day supply)	$10 copay – generic formulary drugs $20 copay – brand-name formulary drugs $35 copay – non-formulary drugs	Not covered

Type of Service or Supply	In-Network Care Care provided by in-network providers	Out-of-Network Care Care from out-of-network providers
Additional Services		
TMJ	Covers diagnostic and surgical procedures involving the bones and joints of the face and jaw when medically necessary to treat congenital or developmental deformity, disease or injury. Copay based on where service is provided.	70% after deductible

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

Primary and Preventive Care

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

Out-of-network primary and preventive care coverage is limited; refer to the "Summary of Benefits."

The Plan covers the following primary and preventive care services:

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your physician.
- Well-child care from birth, including immunizations and booster doses, as recommended by your physician.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Routine gynecological examinations and Pap smears performed by your PCP. You may also visit a participating gynecologist for a routine GYN exam and Pap smear.
- Routine mammograms for female Plan participants age 40 or over.
- Annual mammography screening for asymptomatic women age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their PCP.
  Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.
- Routine immunizations (except those required for travel or work).
- Periodic eye examinations. You may visit a participating provider as follows:
  If you wear eyeglasses or contact lenses:
  - age 1-18 years - one exam every 12 months.
  - age 19 or over - one exam every 24 months.
  If you do not wear eyeglasses or contact lenses:
  - age 1-44 years - one exam every 36 months.
  - age 45 or over - one exam every 24 months.
- Routine hearing screenings.
- Injections, including routine allergy desensitization injections.

Specialty and Outpatient Care

The following services and supplies are covered after the applicable copayment or coinsurance. If these services are obtained on an out-of-network basis, they are subject to the Plan's deductible, coinsurance and maximum benefit limitations, shown in the "Summary of Benefits." Some out-of-network services may also require precertification; refer to the listing under the "Precertification" section.

- Participating specialist office visits by appointment.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance (precertified) by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy and cancer hormone treatments and services that have been approved by the U.S. Food and Drug Administration (FDA) for general use in the treatment of cancer.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis when medically necessary following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis when medically necessary for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see "In Case of Emergency").
- Home health services provided by a home health care agency, including:
  - skilled nursing services provided by, or supervised by, an RN.
  - services of a home health aide for skilled care.
  - medical social services provided by, or supervised by, a qualified physician or social worker if your physician certifies that the medical social services are necessary for the treatment of your medical condition.

- Outpatient hospice services for a Plan participant who is terminally ill, including:
  - counseling and emotional support.
  - home visits by nurses and social workers.
  - pain management and symptom control.
  - instruction and supervision of a family member.

  Note: The Plan does ***not*** cover:
    - bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
    - homemaker or caretaker services, and any service not solely related to the care of the terminally ill patient.
    - respite care when the patient's family or usual caretaker cannot, or will not, attend to his or her needs.
- Oral surgery (limited to extraction of bony impacted teeth, treatment of bone fractures, and removal of tumors and orthodontogenic cysts).
- Reconstructive breast surgery following a mastectomy, including:
  - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
  - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
  - medically necessary physical therapy to treat the complications of the mastectomy, including lymphedema.
- Infertility services to diagnose and treat the underlying medical cause of infertility. You may obtain the following **basic** infertility services from a participating gynecologist or infertility specialist:
  - initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
  - evaluation of ovulatory function,
  - ultrasound of ovaries at an appropriate participating radiology facility,
  - postcoital test,
  - hysterosalpingogram,
  - endometrial biopsy, and
  - hysteroscopy.

  Semen analysis at an appropriate participating laboratory is covered for male Plan participants; preauthorization by Aetna is required.

  If you do not conceive after receiving the above infertility services, or if the diagnosis suggests that there is no reasonable chance of pregnancy as a result of the above services, you are eligible to receive the following **comprehensive** services through a participating infertility specialist **when preauthorized through and coordinated by the Aetna Infertility Unit**:
  - ovulation induction cycles (bloodwork and ultrasounds), subject to a lifetime maximum of 6 cycles,
  - artificial insemination, subject to a lifetime maximum of 6 attempts, and
  - infertility surgery (diagnostic or therapeutic).
- Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist.

- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth) when approved by Aetna.
- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury, and preauthorized by Aetna.
  The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:
  - they are needed due to a change in your physical condition, or
  - it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

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

Inpatient Hospital, Skilled Nursing Facility and Hospice Facility Care

If you are hospitalized by a participating physician, you are covered for the services and supplies listed below, as medically necessary. You are responsible for the copayment or coinsurance shown in the "Summary of Benefits." See "Behavioral Health" for inpatient mental health and substance abuse benefits.

Out-of-network inpatient hospital, extended care facility and hospice care facility admissions are subject to the annual deductible, coinsurance and maximum limitations shown in the "Summary of Benefits." When you receive care outside of the network, your benefits for the services listed in the "Precertification" section will be reduced unless you obtain the necessary precertification.

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

types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as a out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Maternity

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

You will receive the Plan's highest level of coverage if a participating obstetrician provides maternity services in a participating facility. A list of participating obstetricians can be found in your provider directory or on DocFind (see "Provider Information").

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

Out-of-network services are subject to the Plan's deductible, coinsurance and maximum benefit limits. In addition, you must precertify certain services to avoid benefit reductions; see the "Precertification" section.

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

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. When you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Mental Health Treatment

The Plan covers the following services for mental health treatment:

- **Inpatient** medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.

- Short-term evaluation and crisis intervention mental health services provided on an **outpatient** basis.

Treatment of Alcohol and Drug Abuse

The Plan covers the following services for treatment of alcohol and drug abuse:

- **Inpatient** care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- **Inpatient** medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an appropriately licensed facility.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services.
- **Outpatient** visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.
  Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

Prescription Drugs

The Plan pays, subject to any limitations specified under "Your Benefits," the cost incurred for outpatient prescription drugs that are obtained from a participating pharmacy. You must present your ID card and make the copayment shown in the "Copayment Schedule" for each prescription at the time the prescription is dispensed.

The Plan covers the costs of prescription drugs, in excess of the copayment, that are:

- Medically necessary for the care and treatment of an illness or injury, as determined by Aetna;
- Prescribed in writing by a physician who is licensed to prescribe federal legend prescription drugs or medicines; and
- Not listed under "Prescription Drug Exclusions and Limitations," below.

Each prescription is limited to a maximum 30-day supply, with refills as authorized by your physician (but not to exceed one year from the date originally prescribed). Non-emergency prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name products where permitted by law.

Coverage is based upon Aetna's formulary. The formulary includes both brand-name and generic drugs and is designed to provide access to quality, affordable outpatient prescription drug benefits. You can reduce your copayment by using a covered generic or brand-name drug that appears on the formulary. Your copayment will be highest if your physician prescribes a covered drug that does not appear on the formulary.

Mail Order Drugs

You may obtain up to a 90-day supply of the drug at a participating mail order pharmacy, if authorized by your physician. The copayment shown in the "Copayment Schedule" will apply to each mail order purchase.

Step-Therapy Program

Your pharmacy benefits plan includes Aetna's step-therapy program. Step-therapy is a type of precertification. Under the step-therapy program, certain drugs are not covered unless you have tried one or more "prerequisite therapy" medication(s) first. However, if it is medically necessary for you to use a step-therapy medication as initial therapy without trying a prerequisite therapy drug, your doctor can request coverage of the step-therapy medication as a medical exception by contacting the Pharmacy Management Precertification Unit.

The step-therapy program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, "cost information" includes any manufacturer rebate arrangements between Aetna and the manufacturers of certain drugs on Aetna's Formulary.

The drugs requiring step-therapy are subject to change. Please call Member Services or visit Aetna's website for the current Step-Therapy List.

Precertification

Your pharmacy benefits plan includes Aetna's precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-authorized by Aetna's Pharmacy Management Precertification Unit before they will be covered. Only your physician can request prior authorization for a drug.

The precertification program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, cost information includes any manufacturer rebate arrangements between Aetna and the manufacturers of certain drugs on Aetna's Formulary.

The drugs requiring precertification are subject to change. Call Member Services or visit Aetna's website for the current Precertification List.

Emergency Prescriptions

You may not have access to a participating pharmacy in an emergency or urgent care situation, or if you are travelling outside of the Plan's service area. If you must have a prescription filled in such a situation, the Plan will reimburse you as follows:

Non-Participating Pharmacy

Coverage for items obtained from a non-participating pharmacy is limited to items connected to covered emergency or out-of-area urgent care services. You must pay the pharmacy directly for the

cost of the prescription. You are responsible for submitting a written request for reimbursement to Aetna, accompanied by the receipt for the prescription. Aetna will review your request and determine whether the event meets the qualifications for reimbursement. If approved, you will be reimbursed for the cost, minus any applicable copayment.

Participating Pharmacy

When you obtain an emergency or urgent care prescription at a participating pharmacy (including an out-of-area participating pharmacy), you must pay the copay. Aetna will not reimburse you if you submit a claim for a prescription obtained at a participating pharmacy.

Covered Drugs

The Plan covers the following:

- Medically necessary outpatient prescription drugs when prescribed by a provider who is licensed to prescribe federal legend drugs or medicines, subject to the terms, limitations, and exclusions described in this booklet.
- FDA-approved prescription drugs when the off-label use of the drug has not been approved by the FDA to treat the condition in question, provided that:
  - the drug is recognized for treatment of the condition in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or
  - the safety and effectiveness of use for the condition has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.
- Diabetic supplies, as follows:
  - diabetic needles and syringes.
  - alcohol swabs.
  - test strips for glucose monitoring and/or visual reading.
  - diabetic test agents.
  - lancets (and lancing devices.
- Contraceptives and contraceptive devices, as follows:
  - oral contraceptives.
  - one diaphragm per 365-day period.
  - up to 5 vials of Depo-Provera in a 365 consecutive-day period. A separate copayment applies to each vial.
  - Norplant and IUDs are covered when obtained from your physician. The office visit copayment will apply when the device is inserted and removed.

Prescription Drug Exclusions and Limitations

Prescription Drug Exclusions

The following services and supplies are not covered by the Plan, and a medical exception is not available for coverage:

- Any drug that does not, by federal or state law, require a prescription order (such as an over-the-counter drug), even when a prescription is written.
- Any drug that is not medically necessary.
- Charges for the administration or injection of a prescription drug or insulin.
- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth, including (but not limited to) health and beauty aids.
- Any prescription for which the actual charge to you is less than the copayment.
- Any prescription for which no charge is made to you.
- Insulin pumps or tubing for insulin pumps.
- Medication which is to be taken by you or administered to you, in whole or part, while you are a patient in a licensed hospital or similar facility.
- Take-home prescriptions dispensed from a hospital pharmacy upon discharge from the hospital, unless the hospital pharmacy is a participating retail pharmacy.
- Any medication that is consumed or administered at the place where it is dispensed.
- Immunization or immunological agents, including:
  - biological sera.
  - blood, blood plasma or other blood products administered on an outpatient basis.
  - allergy sera and testing materials.
- Drugs used for the purpose of weight reduction, including the treatment of obesity.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Drugs labeled "Caution - Limited by Federal Law to Investigational Use" and experimental drugs.
- Drugs prescribed for uses other than the uses approved by the FDA under the Food, Drug and Cosmetic Law and regulations.
- Medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use.
- Prescription drugs purchased prior to the effective date, or after the termination date, of coverage under this Plan.
- Replacement of lost or stolen prescriptions.
- Drugs used to aid or enhance sexual performance, including (but not limited to):
  - Sildenafil citrate (e.g. Viagra), phentolamine, apomorphine and alprostadil in oral, injectable, and topical (including but not limited to gels, creams, ointments and patches) forms, and
  - any prescription drug in oral, topical, or any other form that is in a similar or identical class, has a similar or identical mode of action, or exhibits similar or identical outcomes, unless otherwise covered under this plan.

- Performance, athletic performance, or lifestyle-enhancement drugs and supplies.
- Smoking-cessation aids or drugs.
- Growth hormones.
- Test agents and devices, except diabetic test strips.
- Needles and syringes, except diabetic needles and syringes.
- Injectable drugs, except insulin and injectable contraceptives. The Plan does not cover injectable drugs used in the treatment of infertility.

Prescription Drug Limitations

The following limitations apply to the prescription drug coverage:

- A participating retail or mail order pharmacy may refuse to fill a prescription order or refill when, in the professional judgment of the pharmacist, the prescription should not be filled.
- Prescriptions may be filled only at a participating retail or mail order pharmacy, except in the event of emergency or urgent care. Plan participants will not be reimbursed for out-of-pocket prescription purchases from either a participating or non-participating pharmacy in non-emergency, non-urgent care situations.
- The Plan is not responsible for the cost of any prescription for which the actual charge to you is less than the copayment, or for any prescription for which no charge is made to you.
- Plan participants must present their ID cards at the time each prescription is filled to verify coverage. If you do not present your ID card, your purchase may not be covered by the Plan, except in emergency and urgent care situations, and you may be required to pay the entire cost of the prescription.

Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by Aetna.
- Blood, blood plasma, or other blood derivatives or substitutes.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
  - reconstructive surgery to correct the results of an injury.
  - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
  - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary.
- Custodial care and rest cures.
- Dental care and treatment, including (but not limited to):
  - care, filling, removal or replacement of teeth,
  - dental services related to the gums,
  - apicoectomy (dental root resection),
  - orthodontics,
  - root canal treatment,
  - soft tissue impactions,
  - alveolectomy,
  - augmentation and vestibuloplasty treatment of periodontal disease,
  - prosthetic restoration of dental implants, and
  - dental implants.

  However, the Plan does cover oral surgery as described under "Your Benefits."

- Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.
  This exclusion will not apply to drugs:
  - that have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
  - that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
  - that Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.

  Refer to the "Glossary" for a definition of "experimental or investigational."
- False teeth.
- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids, eyeglasses, or contact lenses or the fitting thereof.
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work.
- Implantable drugs (except as described under "Prescription Drugs").
- Infertility services, except as described under "Your Benefits." The Plan does not cover:
  - purchase of donor sperm and any charges for the storage of sperm.
  - purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
  - cryopreservation and storage of cryopreserved embryos.
  - all charges associated with a gestational carrier program (surrogate parenting) for the Plan participant or the gestational carrier.
  - drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
  - injectable infertility drugs.
  - the costs for home ovulation prediction kits.
  - services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.

  - services for females with FSH levels greater than 19 mIU/ml on day 3 of the menstrual cycle.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips, (except as described under "Prescription Drugs.")
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Private duty or special nursing care.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
  - obtaining or continuing employment,
  - obtaining or maintaining any license issued by a municipality, state or federal government,
  - securing insurance coverage,
  - travel, and
  - school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.
- Services that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:
  - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,
  - needles, syringes and other injectable aids (except as described under "Prescription Drugs"),
  - drugs related to treatments not covered by the Plan, and

  - drugs related to the treatment of infertility, contraception, and performance-enhancing steroids (except as described under "Prescription Drugs").
- Specific non-standard allergy services and supplies, including (but not limited to):
  - skin titration (wrinkle method),
  - cytotoxicity testing (Bryan's Test),
  - treatment of non-specific candida sensitivity, and
  - urine autoinjections.
- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):
  - primal therapy.
  - chelation therapy.
  - rolfing.
  - psychodrama.
  - megavitamin therapy.
  - purging.
  - bioenergetic therapy.
  - vision perception training.
  - carbon dioxide therapy.
- Thermograms and thermography.
- 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.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under "Your Benefits."
- Treatment of sickness or injury covered by a worker's compensation act or occupational disease law, or by United States Longshoreman's and Harbor Worker's Compensation Act.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
  - treatment performed by placing a prosthesis directly on the teeth,
  - surgical and non-surgical medical and dental services, and
  - diagnostic or therapeutic services related to TMJ.
- Weight reduction programs and dietary supplements.

Limitations

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

In Case of Emergency

Guidelines

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

> *An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:*
>
> - *Placing the health of the individual (or, with respect to a pregnant woman; the health of the woman or her unborn child) in serious jeopardy;*
> - *Serious impairment to bodily function; or*
> - *Serious dysfunction of any bodily organ or part.*

Some examples of emergencies are:

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

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

1. Call your PCP first, if possible. Your PCP is required to provide urgent care and emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility, or dial 911 or your local emergency response service.
2. After assessing and stabilizing your condition, the emergency facility should contact your PCP so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible. The emergency room copayment will be waived if you are admitted to the hospital.
4. Services which do not qualify as an emergency under your in-network benefits will be subject to the deductible, coinsurance and maximum benefit limits shown in the "Summary of Benefits."

Follow-Up Care After Emergencies

Follow-up care following emergency treatment is covered by the Plan. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain for an urgent medical condition is covered if:

- The service is a covered benefit; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Some examples of urgent medical conditions are:

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

Follow-up care provided by your PCP is covered, subject to the office visit copayment. Other in-network follow-up care is covered, subject to the applicable copay shown in the "Summary of Benefits."

Out-of-network follow-up care is subject to the Plan's deductible, coinsurance and maximum benefits.

What to Do Outside Your Aetna Service Area

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

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

Special Programs

Alternative Health Care Programs

Natural Alternatives - If you are interested in alternative therapies such as acupuncture or massage therapy, Aetna has a program to meet your needs. Aetna's Natural Alternatives program offers you special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapists and nutritional counselors.

Vitamin Advantage™ - You can save on vitamins and nutritional supplements purchased through mail order, over the phone, by fax, or over the Internet.

Natural Products - You also can save on many health-related products, including aromatherapy, foot care and natural body care products.

You may place orders by mail, telephone, fax or Internet to receive savings on health-related products offered through these programs.

To Find Out More - Call the Member Services number on your ID card, or visit Aetna on the web at **http://www.aetna.com/products/natural_alt_99.html**. There you can find a listing of participating providers, vendors and the latest additions to the product list. Visit the website often — these programs are growing!

Natural Alternatives is not available in all states.

Fitness Program

Aetna offers Plan participants access to discounted fitness services provided by GlobalFit™. Depending upon your location, you may be eligible for one of two GlobalFit programs.* Under ***GlobalFit A***, Plan participants can join the GlobalFit network and receive discounts on their health club membership rate. Under ***GlobalFit B***, Plan participants can join included clubs directly, receiving the club's lowest corporate rate for the type of membership selected. Both programs offer Plan participants:

- Low or discounted membership rates at independent health clubs contracted with GlobalFit;
- Free guest passes to allow you to sample facilities before selecting a club** to join;
- Guest privileges at other participating GlobalFit health clubs,** and
- Discounts on certain home exercise equipment.

* *For current club members, participation under this program may not be available at all clubs.*
** *Not available at all clubs.*

To determine which program is offered in your area and to view a list of included clubs, visit the GlobalFit website at **www.globalfit.com/fitness**. If you would like to speak with a GlobalFit representative, you can call the GlobalFit Health Club Help Line at 1-800-298-7800.

Healthy Outlook Program® -- Disease Management for the 21st Century

Aetna has four programs aimed at helping Plan participants and their physicians to better manage chronic disease.

Asthma Management Program (pediatric and adult)

The Asthma Management program integrates comprehensive asthma education and instruction in the use of asthma management equipment designed for home use.

Heart Failure Management Program

This program enables patients to receive certain intravenous drugs in the convenience of home and provides education to help them improve their lifestyle and reduce the risk of future hospitalizations.

Diabetes Management Program

The Diabetes Management Program combines patient education with blood glucose self monitoring to help achieve better blood sugar control and lessen the chance for the complications of diabetes to develop.

Low Back Pain Disease Management Program

This program provides access to educational materials to help prevent flare-ups of low back pain.

Additional information about Aetna's Disease Management Programs can be found on Aetna's website at **http://www.aetna.com/products/extra/healthy_outlook.html**.

Health Education Programs

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

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

Adolescent Immunization

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

Adult Preventive Reminders

Preventive care recommendations can overlap in some cases for people age 50 and older. Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats for people in this age group.

Vaccination programs against diseases such as influenza and pneumococcal pneumonia have been shown to reduce the incidence of illness and death from these diseases.

Aetna sends annual reminders stressing the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screening.

Cancer Screening Programs

Early detection and treatment is important in helping Plan participants lead longer, healthier lives. Health Education provides Plan participants with an important means of early detection.

Breast Cancer Screening

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease. The mailer may also include information on participating mammography centers or information for women who have chosen a primary care physician with a capitated radiology office.

Cervical

Gynecological examinations and Pap smears are vital to women's health because they are often the first step in the detection and treatment of abnormalities. This program reminds female Plan participants, starting at 18 years of age, to get exams and Pap smears on a regular basis. Annually, women are sent information stressing the importance of annual gynecological exams, direct access to care, as well as instructions on how to perform breast self-examination.

Colorectal

The colorectal cancer cure rate can exceed 80 percent when detected early. We encourage you to discuss questions about colorectal cancer screening with your physician. Together you and your physician can choose the most appropriate method of colorectal cancer screening. Aetna sends annual reminders stressing the importance of completing appropriate colorectal cancer screening.

Childhood Immunization Program

Children need immunizations to protect them from a number of dangerous childhood diseases that could have very serious complications. Vaccines have been proven to be powerful tools for preventing certain diseases. It has been shown over time that the risks of serious illness from not vaccinating children far outweigh any risk of reaction to immunization. The common childhood diseases that vaccinations can guard against are:

- Measles
- Mumps
- Rubella
- Polio
- Pertussis (whooping cough)
- Diphtheria
- Tetanus
- Haemophilus influenzae type B
- Hepatitis B
- Varicella (chicken pox)

To promote good health through prevention, the Childhood Immunization Program sends immunization reminders to parents of children covered under this Plan.

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. This reminder contains a list of immunizations recommended at 18 months.* The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing immunizations.

If you have questions about specific vaccinations, please call your pediatrician or your family doctor.

**Source: Office of Prevention and Health Promotion, in cooperation with the agencies of Public Health Services, U.S. Department of Health and Human Services. Center for Disease Control and Prevention (CDC), American Association of Pediatrics (AAP), and Advisory Committee on Immunization Practices.*

Healthy Breathing® Program

Quitting smoking is one of the biggest steps people can take to improve their health. Millions of people successfully quit smoking each year. That's why Aetna offers the Healthy Breathing Program, which provides access to the GlaxoSmithKline's Committed Quitters® service. The program is available to Plan participants. The program is an 8- to 12-week smoking cessation program that uses nicotine replacement therapy and a personal quit plan to help smokers break their addiction to cigarettes.

Eligible Plan participants who call Member Services using the toll-free telephone number on their Aetna ID card can obtain a brochure that contains a $5 coupon redeemable for the purchase of either a Nicorette® (nicotine gum) or NicoDerm®CQ® (nicotine patch) Starter Kit*. These products can help ease the craving for nicotine and improve the chances of quitting successfully. They are available without a doctor's prescription, although you should discuss use of these products with your physician.

You can call the 1-800 number in the Starter Kit to begin a quit program or register on line at **www.committedquitters.com**. A personal quit plan usually arrives within a week after calling the 1-800 number. Over the following weeks, you are then sent materials that include information on coping strategies and how to use GlaxoSmithKline's Nicorette or NicoDerm CQ safely and effectively.

If you are an eligible Plan participant, you may call the Member Services number on your Aetna ID card to request the Healthy Breathing brochure.

**Committed Quitters®, Nicorette®, NicoDerm®, and CQ® are registered trademarks owned by and/or licensed to GlaxoSmithKline and are used under license.*

Healthy Eating™ Program

Aetna's *Healthy Eating* booklet provides an easy-to-follow approach to overall better health through good nutrition. The information provides you and your family with tools you can use to develop a healthy eating plan that's realistic. Following a nutritious diet can help you:

- Reduce your risk of illness and disease
- Manage your weight
- Boost your ability to fight illness
- Increase your energy levels
- Look and feel your personal best
- Improve your performance

The *Healthy Eating* booklet outlines the benefits of a healthy diet and how to get started. It's geared toward helping you understand and use the Food Guide Pyramid, read the "Nutrition Facts" labels on most foods, lower the amount of fat you eat, and become more physically active. Sensible weight management is also addressed. The booklet is available to all Plan participants.

Call the Member Services number on your Aetna ID card to request the Healthy Eating booklet.

Healthy Insights Newsletter

Aetna periodically publishes the *Healthy Insights* newsletter. The newsletter features health-related information, education about various benefits and issues important to quality management and patient management. *Healthy Insights* is an important resource that communicates with Plan participants about a wide variety of topics.

Informed Health® Line

Informed Health® Line provides eligible Plan participants with telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses encourage informed health care decision making and optimal patient/provider relationships through information and support. However, the nurses do not diagnose, prescribe or give medical advice.
Informed Health Line is available to eligible employees and their families virtually 24 hours per day, 365 days per year from anywhere in the nation.

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

Numbers-to-Know™ -- Hypertension and Cholesterol Management

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

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

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

National Medical Excellence Program®

Aetna's National Medical Excellence Program® helps eligible Plan participants access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services.

The program has three components:

- National Transplantation Program, designed to help arrange care for solid organ and bone marrow transplants
- National Special Case Program, developed to coordinate arrangements for treatment of Plan participants with complex conditions at tertiary care facilities across the country when that care is not available within 100 miles of the Plan participant's home
- Out of Country Program, designed for Plan participants who need emergency inpatient medical care while temporarily traveling outside the United States.

If you need a transplant or other specialized care that cannot be provided within the service area, the NME Program will coordinate covered services and will provide the following lodging and travel expenses if you must travel more than 100 miles:

- Transportation expenses you and a companion (if applicable) incur while traveling between your home and the Program facility. Travel expenses incurred by more than one companion are not covered.
- As the NME patient, your lodging expenses incurred while traveling between your home and the National Medical Excellence facility to receive covered services;
- The lodging expenses you incur for lodging away from home to receive covered outpatient services from a NME Program provider;
- The lodging expenses incurred by a companion traveling with you from your home to a National Medical Excellence provider so you can receive covered services; and
- Your companion's lodging expenses when their presence is required to enable you to receive services from a NME Program provider on either an inpatient or outpatient basis. Only the lodging expenses incurred by **one** companion are covered per night.

Benefits for travel and lodging expenses are subject to a maximum of $10,000 per episode of care. Lodging expenses are subject to a $50 per night maximum for each person.

Travel and lodging expenses must be approved in advance by Aetna; if you do not receive approval, the expenses are ***not*** covered.

You become eligible for coverage of travel and lodging expenses on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest to occur of:

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

Travel and lodging expenses do not include expenses that are covered under any other part of the Plan.

The Plan covers only those services, supplies and treatments that are considered necessary for your medical condition. Treatment that is considered experimental (as determined by Aetna) is ***not*** covered by the Plan. Refer to the *Glossary* for a definition of "experimental."

Vision One® Discount Program

Plan participants are eligible to receive discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions through the Vision One program at thousands of locations nationwide. Just call 1-800-793-8616 for information and the location nearest you.

Plan participants are also eligible to receive a discount off the provider's usual retail charge for Lasik surgery (the laser vision corrective procedure) offered by Cole/LCA-Vision LLC through the national Lasik network of LCA Vision, Inc. Included in the discounted price is patient education, an initial screening, the Lasik procedure and follow-up care. To find the closest surgeons, call 1-800-422-6600 and speak to a Lasik customer service representative.

Vision One is a registered trademark of Cole Vision.

Women's Health Care

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

Breast Cancer Case Management

Aetna's breast cancer case management program assists female Plan participants who have been diagnosed with breast cancer in making informed choices for their care. This special educational and support program includes:

- A dedicated breast cancer nurse case manager to answer your questions about coverage, assist with necessary claims authorizations, and facilitate access to treatment by participating specialists and primary care physicians and at participating facilities.
- Educational materials, including *The Wellness Community Guide to Fighting for Recovery From Cancer.*
- Second opinions at participating facilities.

Case Management and Education for Diabetics Considering Pregnancy

Aetna provides diabetic women considering pregnancy with educational materials and nurse case management to help better manage their blood sugar levels prior to pregnancy, which can decrease the chance of delivering babies with birth defects.

Confidential Genetic Testing for Breast and Ovarian Cancers

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

Direct Access for OB/GYN Visits

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

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

Infertility Case Management and Education

Infertility treatment can be an emotional experience for couples. Aetna's infertility case management unit provides Plan participants with educational materials and assistance with coordinating covered infertility care. A dedicated team of registered nurses and infertility coordinators staffs the unit.

Menopause Education

Beginning at age 40, each female Plan participant (who has selected a primary care physician) receives educational information about menopause with her annual mammography reminder. This includes a take-at-home osteoporosis self-evaluation, which she can complete and discuss with her provider.

Moms-to-Babies Maternity Management Program™

The Moms-to-Babies™ maternity management program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Assistance in accessing prenatal care.
- Case management by registered nurses, who will assist in arranging covered services, coordinate covered specialty care, review the program's features and answer general pregnancy-related questions.
- Smoke-free Moms-to-be™, a personalized stop-smoking program designed specifically for pregnant women.
- Focused, educational information, "For Dad or Partner."
- A comprehensive pregnancy handbook.

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

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

Eligibility

Who Is Eligible to Join the Plan

You are eligible to enroll in the Plan if you are a full-time employee of Lee County BoCC, you are regularly scheduled to work 30 or more hours per week and you work or reside in the Plan's service area. Coverage begins on the first of the month following one full month of employment.

When you join the Plan, your spouse and your dependent children are also eligible to join. A dependent child must be unmarried and under the age of 25. Coverage will continue until end of the year in which the child attains age 25.

You may enroll your natural child, foster child, stepchild, legally adopted child, a child under court order, or a grandchild* in your court-ordered custody. Dependents eligible to participate include a lawful spouse, and children, up to the last day of the calendar year in which they attain age 25 if a full-time/part-time student at an accredited school, college or university, and dependent upon the employee for support; or, residing in the household of the employee, and dependent upon the employee for support; each unmarried, natural, adopted from-moment of-placement in the home, step or foster child, and children under court-appointed legal guardianship, who are either (a) full-time or part-time student at an accredited school, college, or university, and dependent upon the employee for support; or, (b) residing in the household of the employee and dependent upon the employee for support. Benefits may be extended for a dependent child who is physically or mentally handicapped.

* A grandchild may be added if the parent is covered as a dependent under the Plan when the child is born. The grandchild may remain covered under the Plan for up to 18 months as long as the parent is a Plan Participant and meets the definition of dependents above.

No person may be covered as both an employee and a dependent under the Plan, and no person may be covered as a dependent of more than one employee.

If Your Child Is Adopted

Coverage for your legally adopted child is effective on the date the child is adopted or placed with you for adoption if you request coverage for the child in writing within 31 days of the placement.

If Your Child Does Not Reside With You

If your child does not live with you, but they live in another Aetna service area, they can choose a PCP in that service area. Your child's coverage under the Plan will then be the same as yours.

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

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

If Your Child Is Handicapped

Unmarried children of any age who are handicapped may also be covered. Your child is handicapped if:

- He or she is not able to earn his or her own living because of a mental or physical disability which started prior to the date he or she reached age 25; and
- He or she depends chiefly on you for support and maintenance.

You must provide proof of your child's handicap no later than 31 days after the child's coverage would otherwise end.

Coverage for a handicapped child ends on the first to occur of the following:

- The child's handicap ceases;
- You fail to provide proof that the handicap continues;
- The child fails to have a required examination by an Aetna participating PCP; or
- The child's coverage as a dependent under the Plan ceases for any reason ***other than*** attainment of the maximum age for dependent coverage.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a court order requiring a parent to provide health care benefits to one or more children. Coverage under the Plan can be extended to a child who is covered by a QMCSO, if:

- The QMCSO is issued on or after the date your coverage becomes effective; and
- Your child meets the definition of an eligible dependent under the Plan; and
- You request coverage for the child within 31 days of the court order.

Coverage will be effective on the date of the court order.

Enrollment

New Employees

When you are first eligible to enroll in the Plan, you will be given enrollment and benefit information, including an enrollment form. You must complete the enrollment form and return it to your Human Resources representative within 31 days of the date you become eligible if you wish to participate in the Plan. If you do not return the form within the 31-day period, Lee County BoCC will assume that you have waived coverage, and you will not be allowed to participate in the Plan until the next open enrollment period, unless you have a change in status.

Open Enrollment

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

Change in Status

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

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

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

Note: Newborn children are automatically covered for 31 days after birth. To continue the coverage beyond 31 days, you must apply by submitting a change form to your Human Resources representative within the 31-day period.

When Coverage Ends

Termination of Employee Coverage

Your coverage will end if:

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

Termination of Dependent Coverage

Coverage for your dependents will end if:

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

Termination for Cause

A Plan participant's coverage may be terminated for cause. "For cause" is defined as:

- **Untenable relationship**: After reasonable efforts, Aetna and/or the Plan's participating providers are unable to establish and maintain a satisfactory provider-patient relationship with you or a Plan participant of your family. You will be given 31 days advance written notice of the termination of coverage.
- **Failure to make copayments**: You or a member of your family fails to make any required copayment or any other payment that you are obligated to pay. You will be given 31 days advance written notice of the termination of coverage.
- **Refusal to provide COB information**: You or a member of your family refuses to cooperate and provide any facts necessary for Aetna to administer the Plan's COB provision. You will be given 31 days advance written notice of the termination of coverage.
- **Furnishing incorrect or incomplete information**: You or a member of your family willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in, or obtaining benefits from, the Plan. Termination will be effective immediately.

- **Fraud against the Plan**: This may include, but is not limited to, allowing a person who is not a participant of the Plan to use your Aetna ID card. Termination will be effective immediately.
- **Misconduct**: You or a covered member of your family abuses the system, including (but not limited to) theft, damage to the property of a participating provider, or forgery of drug prescriptions. Termination will be effective immediately.

No benefits will be provided to you and your family members once coverage is terminated.

Any termination for cause is subject to review in accordance with the Plan's grievance process. You may request that Aetna conduct a grievance hearing within 15 working days after receiving notice that coverage has been or will be terminated. Coverage will be continued until a final decision on the grievance is rendered, provided you continue to make required contributions. Termination may be retroactive to the original date of termination if the final decision is in favor of Aetna.

Family and Medical Leave

If Lee County BoCC grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by Lee County BoCC to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, Lee County BoCC may recover from you the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is terminated because of your gross misconduct, you will not be eligible for COBRA continued coverage.

COBRA Continuation of Coverage

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

Continuation of Coverage Following Termination of Employment or Loss of Eligibility

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

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

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

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

Continuation of Coverage Due to Other Qualifying Events

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

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

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

Applying for COBRA Continuation

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

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

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

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

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

... whichever happens later.

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

When COBRA Continuation Coverage Ends

Continuation coverage will end on the earliest date that:

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

Portability of Coverage

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Lee County BoCC will give you a certificate confirming your participation in the Plan when your employment terminates. Certificates can be obtained from your Human Resources representative.

Coordination of Benefits

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

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

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

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

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

- If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.
- The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.
- If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

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

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

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

Right of Recovery (Subrogation and/or Reimbursement)

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to all rights of recovery a covered Plan participant has against any party potentially responsible for making any payment to that Plan participant due to the Plan participant's injuries or illness, to the full extent of benefits provided or to be provided by the Plan. In addition, if a covered Plan participant receives any payment from any potentially responsible party as a result of an injury or illness, the Plan has the right to recover from, and be reimbursed by, the Plan participant for all amounts this Plan has paid and will pay as a result of that injury or illness, up to and including the full amount the Plan participant receives from all potentially responsible parties. A "covered Plan participant" includes, for the purposes of this provision, anyone on whose behalf the Plan pays or provides any benefit, including (but not limited to) the minor child or dependant of any Plan participant or person entitled to receive any benefits from the Plan.

As used throughout this provision, the term "responsible party" means any party possibly responsible for making any payment to a covered Plan participant due to that Plan participant's injuries or illness or any insurance coverage, including (but not limited to) uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, med-pay coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The covered Plan participant shall do nothing to prejudice the Plan's subrogation and reimbursement rights and shall, when requested, fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the covered Plan participant to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the covered Plan participant.

The covered Plan participant acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties and are to be paid to the Plan before any other claim for the Plan participant's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the covered Plan participant which is insufficient to make the Plan participant whole or to compensate the Plan participant in part or in whole for the damages sustained. It is further agreed that the Plan is not required to participate in or pay attorney fees to the attorney hired by the Plan participant to pursue the covered person's damage claim.

The terms of this entire subrogation and reimbursement provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the covered Plan participant identifies the medical benefits the Plan provided. The Plan is entitled to recover from ***any and all*** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the covered Plan participant and this Plan agree that Aetna shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Claim Procedures

A claim occurs whenever a Plan participant requests:

- An authorization or referral from a participating provider or Aetna; or
- Payment for items or services received.

Because you are a participant in an HMO-type plan, you do not need to submit a claim for most of your covered healthcare expenses. However, if you receive a bill for covered services, the bill must be submitted promptly to Aetna for payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card.

Aetna will make a decision on your claim. For **concurrent care** claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive notice if Aetna makes an **adverse benefit determination**.

Adverse benefit determinations are decisions Aetna makes that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:
  - it is not included in the list of covered benefits,
  - it is specifically excluded,
  - a Plan limitation has been reached, or
  - it is not medically necessary.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown below. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see "Complaints and Appeals" for more information about appeals.

Type of Claim	Response Time
Urgent care claim: a claim for medical care or treatment where delay could: Seriously jeopardize your life or health, or your ability to regain maximum function; or Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care.	15 calendar days
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Urgent care claim - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment. Other claims - 15 calendar days
Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.	With enough advance notice to allow the Plan participant to appeal.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days

Extensions of Time Frames

The time periods described in the chart may be extended.

For urgent care claims: If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided.

For non-urgent pre-service and post service claims: The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

If an extension is necessary because Aetna needs more information to process your post service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you fail to provide the information, your claim will be denied.

Grievances and Appeals

The Plan has procedures for you to follow if you are dissatisfied with a decision that Aetna has made or with the operation of the Plan. The process depends on the type of complaint you have. There are two categories of complaints:

- Quality of care or operational issues; and
- Adverse benefit determinations.

Complaints about quality of care or operational issues are called grievances. Complaints about adverse benefit determinations are called appeals.

Grievances

Quality of care or operational issues arise if you are dissatisfied with the service received from Aetna or want to complain about a participating provider. To make a complaint about a quality of care or operational issue (called a grievance), call or write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written decision within 30 calendar days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will specify what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

Aetna will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made in writing within 180 days from the date of the notice.

The Plan provides for two levels of appeal plus an option to seek External Review of the adverse benefit determination. You must complete the two levels of appeal before bringing a lawsuit against the Plan. The following chart summarizes some information about how appeals are handled for different types of claims. In certain situations, the time frames shown may be extended.

Type of Claim	Level One Appeal: Response Time From Receipt of Appeal	Level Two Appeal: Response Time From Receipt of Appeal
Urgent care claim: a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.	36 hours Review provided by Appeals Committee.
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care.	15 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	15 calendar days Review provided by Appeals Committee.
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim, depending on the circumstances	Treated like an urgent care claim or a pre-service claim, depending on the circumstances
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	30 calendar days Review provided by Appeals Committee.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

You and/or an authorized representative may attend the Level 2 appeal hearing and question the representative of Aetna and any other witnesses, and present your case. The hearing will be informal. You may bring your physician or other experts to testify. Aetna also has the right to present witnesses.

If the Level One and Level Two appeals uphold the original adverse benefit determination, you may have the right to pursue an External Review of your claim. See "External Review" for more information.

External Review

You may file a voluntary appeal for external review of any final appeal determination that qualifies.
You must complete the two levels of appeal described above before you can appeal for external review. 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 must request this voluntary level of review within 60 days after you receive the final denial notice.

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.

An external review is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials and denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment. You may request a review by an external review organization (ERO) if:

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

The final claim denial letter you receive 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 60 calendar days of the date you received the final claim denial letter. The form must be accompanied by a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the Request for External Review Form, and will follow the applicable plan's contractual documents and plan criteria governing the benefits. You will generally be notified of the decision of the External Review Organization within 30 days of Aetna's receipt of your request form and all necessary information. An expedited review is available if your physician certifies (by telephone or on a separate Request for External Review

Form) that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within 3-5 calendar days after Aetna receives the request.

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

Claim Fiduciary

Aetna has complete discretionary authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, Aetna has discretionary authority to:

Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and

Construe any disputed or doubtful terms of the Plan.

Aetna has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. Aetna may not abuse its discretionary authority by acting arbitrarily and capriciously.

Lee County BoCC is responsible for making reports and disclosures required by applicable laws and regulations.

Member Services Department

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

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

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

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

Internet Access

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

When you visit the Member Services site, you can:

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

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

InteliHealth®

InteliHealth is Aetna's online health information affiliate. It was established in 1996 and is one of the most complete consumer health information networks ever assembled. Through this unique program, Plan participants have access, via the Internet, to the wisdom and experience of some of the world's top medical professionals in the field today. Access InteliHealth through the Aetna Internet website home page or directly via **www.intelihealth.com**.

Aetna Navigator™

Aetna Navigator provides a single location for the health and medical issues that matter most to you.

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from InteliHealth®. Access Aetna Navigator™ through the Aetna Internet website home page or directly via **www.aetnanavigator.com**.

When you visit the website, you can see some of Aetna Navigator's distinct features:

- A wealth of health information from InteliHealth, a premier provider of online consumer-based health, wellness and disease-specific information.
- Online customer service functions that allow you to change your primary care physician or primary care dentist, order ID cards and send e-mail inquiries to Member Services.
- Interactive "Cool Tools," including a medical dictionary, allergy and asthma quizzes, a pregnancy due-date calculator and a heart and breath odometer. To access "Cool Tools," look under "Health Tools."
- A preventive care planner that includes recommendations for screenings and immunizations.

Plan participants with certain Aetna plans may also create password-protected Web pages that are personalized to their health care interests. They have access to the features listed above as well as other options including:

- A personal "benefits snapshot" and claims summary.
- DocFind-A-Specialist, our enhanced online provider directory that helps Plan participants select a specialist based on personal needs and preferences.
- An online survey that allows you to receive customized information based on your personal health interests.

Your Rights and Responsibilities

As a Plan participant, you have a right to:

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

As a Plan participant, you have the responsibility to:

- Choose a PCP from the Plan's network and form an ongoing patient-doctor relationship.
- Help your doctor make decisions about your health care.
- Tell your PCP if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Consult with your PCP for non-emergency referrals to specialist or hospital care.
- See the specialists your PCP refers you to.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Call your PCP before getting care at an emergency facility, unless a delay would be detrimental to your health.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your membership card to providers before getting care from them.
- Pay the copayments, coinsurance and deductibles required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments and what services are covered and what services are not covered.

Patient Self-Determination Act (Advance Directives)

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

What Is an Advance Directive?

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

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

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

What Is a Living Will?

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

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

What Is a Durable Power of Attorney for Health Care?

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

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

Who Decides About My Treatment?

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

How Do I Know What I Want?

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

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

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

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

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

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

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

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

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

Do I Have to Execute an Advance Directive?

No. It is entirely up to you.

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

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

Can I Change My Mind After Writing an Advance Directive?

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

What Is the Plan's Policy Regarding Advance Directives?

We share your interest in preventive care and maintaining good health. Eventually, however, every family may face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important in the future and urge you to discuss these topics with your PCP, family, friends, and other trusted, interested people.
You are not required to execute an Advance Directive. **If you choose to complete an Advance Directive, it is your responsibility to provide a copy to your physician and to take a copy with you when you check into a hospital or other health facility so that it can be kept with your medical records.**

How Can I Get More Information About Advance Directives?

Call the Member Services toll-free number on your ID card. Or, you can call Partnership for Caring at Choice in Dying, a community organization, at 1-800-989-9455.

Federal Notices

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

The Newborns' and Mothers' Health Protection Act

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

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

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For more information, see the section entitled *Precertification and Second Opinions*.

The Women's Health and Cancer Rights Act

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

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

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

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

Amendment or Termination of the Plan

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

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

Plan Documents

This plan description covers the major features of the HMO Plan administered by Aetna Life Insurance Company, effective January 1, 2003.

Glossary

Coinsurance - means the sharing of a covered expense by the Plan and the Plan participant. For example, if the Plan covers an expense at 70% (the Plan's coinsurance), your coinsurance share is 30%.

Companion - means a person whose presence as a companion or caregiver is necessary to enable a National Medical Excellence (NME) patient to:

- Receive services from an NME Program provider on an inpatient or outpatient basis; or
- Travel to and from an NME Program provider to receive covered services.

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

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

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

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

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

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

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

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

Durable medical equipment - means equipment determined to be:

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

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

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

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

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

- There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of the Plan participant's particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of the Plan participant's particular condition; or
- It is provided or performed in special settings for research purposes.

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

Hospice care - means a program of care that is:

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

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

Infertility - means:

- For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.
- For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

In-network provider - means a provider that has entered into a contractual agreement with Aetna to provide services to Plan participants.

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

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

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the Plan participant's overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the Plan participant's overall health condition;

- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is medically necessary, Aetna's Patient Management Medical Director or its physician designee will consider:

- Information provided on the Plan participant's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to Aetna's attention.

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

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

Mental or nervous condition - means a condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited to:

- Psychosis;
- Affective disorders;
- Anxiety disorders;

- Personality disorders;
- Obsessive-compulsive disorders;
- Attention disorders with or without hyperactivity; and
- Other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

NME patient - means a person who:

- Requires any National Medical Excellence Program procedure or treatment covered by the Plan;
- Is approved by Aetna as an NME patient; and
- Agrees to have the procedure or treatment performed in a facility designated by Aetna as the most appropriate facility.

Out-of-pocket maximum - means the maximum amount a Plan participant must pay toward covered out-of-network expenses in a calendar year. Once you reach your out-of-pocket maximum, the Plan pays 100% of covered expenses for the remainder of the calendar year. Certain expenses do not apply toward the out-of-pocket maximum:

- Expenses that exceed reasonable and customary limits.
- Charges for services that are not covered by the Plan.
- Penalties for failure to obtain the necessary precertification for the out-of-network services listed under "Precertification."
- Amounts applied toward your deductible.
- Copayments for physician's office visits and prescription drugs.

Outpatient - means:

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

Partial hospitalization - means medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be provided in a hospital or non-hospital facility that is licensed as an alcohol, drug abuse or mental illness treatment program by the appropriate regulatory authority.

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

Plan benefits - means the medical services, hospital services, and other services and care to which a Plan participant is entitled.

Plan participant - means an employee or covered dependent.

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

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

Reasonable and customary - means the charge for a service or supply that is the lower of:

- The provider's usual charge for furnishing it; and
- The prevailing charge for it in the geographic area where it is furnished, as determined by Aetna.

In determining the reasonable and customary charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, Aetna may take into account factors
such as:

- The complexity of the service or supply;
- The degree of professional skill needed;
- The provider's specialty;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

Expenses for covered out-of-network services which exceed reasonable and customary limits are not covered by the Plan, and the excess cannot be applied to the Plan's out-of-pocket limit.

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

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

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

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

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

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

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

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Summary Plan Description

Lee County BoCC

Aetna HMO Plan

Welcome!

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

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

Your Health Maintenance Organization (HMO) benefits program is self-funded by Lee County BoCC and administered by Aetna Life Insurance Company (Aetna).*

We wish you the best of health.

**As used in this booklet, "HMO" refers to HMO-type benefits that are self-funded by Lee County BoCC.*

How to Use Your Summary Plan Description

This booklet is your guide to the benefits available through the Lee County BoCC HMO Plan. Please read it carefully and refer to it when you need information about how the Plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about many of the special programs available to you as a Plan participant.

If you cannot find the answer to your question(s) in the booklet, call the Member Services toll-free number on your ID card. A trained representative will be happy to help you. For more information, go to the "Member Services" section later in this book.

Tips for New Plan Participants

- Keep this booklet where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Post your Primary Care Physician's name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See "In Case of Medical Emergency" for emergency care guidelines.

Table of Contents

How the Plan Works

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

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

The Primary Care Physician

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

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

Primary and Preventive Care

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

Specialty and Facility Care

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

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

To avoid costly and unnecessary bills, follow these steps:

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

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

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

Specialist as Principal Physician Direct Access Program

If you have a serious or complex medical condition, you may need ongoing specialty care. A "serious or complex medical condition" is generally a life-threatening, degenerative or disabling condition or disease such as AIDS, cancer, emphysema, an organ failure that may require a transplant or diabetes with target organ involvement.

The Specialist as Principal Physician Direct Access Program is a voluntary program. Eligibility is based upon the nature of your medical condition, your need for continuing specialty care and a specialist's willingness to serve as your principal physician for treatment of the condition. Enrollment in the program must be approved by Aetna. Once you are enrolled, a case manager will be available to answer questions about the features of the program, to assist with any necessary authorizations or precertifications and to facilitate communications between your PCP and the specialist treating your condition.

If you are interested in enrolling in the Specialist as Principal Physician Direct Access Program, contact Member Services at the toll-free number shown on your ID card and ask to be transferred to a disease management representative.

Provider Information

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

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

Your ID Card

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

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

Copayment Schedule

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

Type of Service or Supply	Benefit Level
Lifetime Maximum	No lifetime maximum
Annual Out of Pocket Limit	
Individual	$1,500
Family	$3,000
Primary and Preventive Care	
PCP Office Visits	$10 copay per visit
After Hours/Home Visits/Emergency Visits	$15 copay per visit
Routine Examinations	$10 copay per visit
Routine Child and Well-Baby Care	$10 copay per visit
Immunizations	$10 copay per visit
Routine Gynecological Exams	$10 copay per visit - direct access (no referral) to participating providers for one routine exam and Pap smear per 365-day period
Routine Mammogram	$10 copay - For women age 35-39, one baseline mammogram, for women age 40 and over, one annual mammogram
Prostate Screening	$10 copay - one annual prostate screening for men age 40 and over
Routine Eye Examinations	$10 copay per visit - direct access (no referral) to participating providers for periodic routine exams
Eyeglasses/Contact Lenses	Discounts available through Vision One Discount Program
Routine Hearing Screenings	Covered when performed as part of a routine exam by PCP. Subject to office visit copay.
Hearing Aids	Not covered
Specialty and Outpatient Care	
Specialist Office Visits	$10 copay per visit
Prenatal Care	$10 copay for the first OB visit
Infertility Services	$10 copay per visit
Advanced Reproductive Technology	Not covered
Allergy Testing	$10 copay per visit
Allergy Treatment Routine injections at PCP's office, with or without physician encounter	$10 copay per visit
X-rays and Lab Tests	$10 copay
Therapy (speech, occupational, physical)	$10 copay per visit - 60 consecutive days per illness or injury
Chiropractic Care	$10 copay per visit - 20 visits per year – direct access (no referral) to participating providers
Dermatologist	$10 copay per visit - up to 5 visits in a 12 month period – direct access (no referral) to participating provider

Type of Service or Supply	Benefit Level
Podiatrist	$10 copay per visit – direct access (no referral) to participating provider
Home Health Care	No copay
Hospice Care	No copay
Durable Medical Equipment (DME)	No copay - must be approved in advance by Aetna
Prosthetic Devices	No copay - some prostheses must be approved in advance by Aetna
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	$250 copay per admission
Skilled Nursing Facilities	$250 copay per admission
Hospice Facility	$250 copay per admission
Surgery and Anesthesia	
Inpatient Surgery	Subject to inpatient copay shown above
Outpatient Surgery	$100 copay - outpatient facility $10 copay - specialist's office
Mental and Nervous Conditions	
Inpatient Treatment	$250 copay per admission - 30 days per year
Outpatient Treatment	$25 copay per visit - 20 visits per year
Partial Hospitalization	1 day of inpatient care may be exchanged for 2 partial hospitalization and/or electroshock sessions in lieu of hospitalization. Must be approved in advance by Aetna.
Inpatient Benefit Exchange	1 day of inpatient treatment may be substituted for 4 outpatient or home health visits, up to a maximum of 10 inpatient days/40 outpatient visits.
Treatment of Alcohol and Drug Abuse	
Inpatient Detoxification	$250 copay per admission
Inpatient Rehabilitation	$250 copay per admission - 30 days per year
Outpatient Detoxification	$10 copay per visit
Outpatient Rehabilitation	$10 copay per visit - 30 visits per year
Emergency Care	
Emergency Room	$75 copay (waived if admitted)
Urgent Care	$25 copay
Ambulance	No copay when medically necessary
Prescription Drugs	No annual maximum
Retail (30-day supply)	$10 copay - generic formulary drugs $20 copay - brand-name formulary drugs $35 copay - non-formulary drugs
Mail Order (up to 90-day supply)	$10 copay - generic formulary drugs $20 copay - brand-name formulary drugs $35 copay - non-formulary drugs

Type of Service or Supply	Benefit Level
Additional Services	
TMJ	Covers diagnostic and surgical procedures involving the bones and joints of the face and jaw when medically necessary to treat congenital or developmental deformity, disease or injury. Copay based on where service is provided.

Your Benefits

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

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

Primary and Preventive Care

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

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your PCP.
- Well-child care from birth, including immunizations and booster doses, as recommended by your PCP.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Routine gynecological examinations and Pap smears performed by your PCP. You may also visit a participating gynecologist for a routine GYN exam and Pap smear without a referral.
- Routine mammograms for female Plan participants age 40 or over.
- Annual mammography screening for asymptomatic women age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their PCP.
  Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.
- Routine immunizations (except those required for travel or work).
- Periodic eye examinations. You may visit a participating provider without a referral as follows:
  If you wear eyeglasses or contact lenses:
  - age 1-18 years - one exam every 12 months.
  - age 19 or over - one exam every 24 months.

  If you do not wear eyeglasses or contact lenses:
  - age 1-44 years - one exam every 36 months.
  - age 45 or over - one exam every 24 months.
- Routine hearing screenings performed by your PCP as part of a routine physical examination.
- Injections, including routine allergy desensitization injections.

Specialty and Outpatient Care

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

The Plan covers:

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see "In Case of Emergency").
- Home health services provided by a participating home health care agency, including:
  - skilled nursing services provided or supervised by an RN.
  - services of a home health aide for skilled care.
  - medical social services provided or supervised by a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.
- Outpatient hospice services for a Plan participant who is terminally ill, including:
  - counseling and emotional support.
  - home visits by nurses and social workers.
  - pain management and symptom control.
  - instruction and supervision of a family member.

  Note: The Plan does ***not*** cover the following hospice services:
    - bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
    - homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.

- respite care when the patient's family or usual caretaker cannot, or will not, attend to the patient's needs.

- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, removal of tumors and orthodontogenic cysts).
- Reconstructive breast surgery following a mastectomy, including:
  - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
  - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
  - physical therapy to treat the complications of the mastectomy, including lymphedema.
- Infertility services to diagnose and treat the underlying medical cause of infertility. You may obtain the following **basic** infertility services from a participating gynecologist or infertility specialist ***without*** a referral from your PCP:
  - initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
  - evaluation of ovulatory function,
  - ultrasound of ovaries at an appropriate participating radiology facility,
  - postcoital test,
  - hysterosalpingogram,
  - endometrial biopsy, and
  - hysteroscopy.

  Semen analysis at an appropriate participating laboratory is covered for male Plan participants; a referral from your PCP is necessary.

  If you do not conceive after receiving the above infertility services, or if the diagnosis suggests that there is no reasonable chance of pregnancy as a result of the above services, you are eligible to receive the following **comprehensive** services through a participating infertility specialist **when preauthorized through and coordinated by the Aetna Infertility Unit**:
  - ovulation induction cycles (bloodwork and ultrasounds), subject to a lifetime maximum of 6 cycles,
  - artificial insemination, subject to a lifetime maximum of 6 attempts, and
  - infertility surgery (diagnostic or therapeutic).
- Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Certain prosthetics require preauthorization by Aetna.
- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury, and preauthorized by Aetna.

  The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:
  - they are needed due to a change in your physical condition, or
  - it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

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

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice

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

The Plan covers:

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

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

Maternity

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

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

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

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

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. You do not need a referral from your PCP to obtain care from participating mental health and substance abuse providers. Instead, when you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Mental Health Treatment

The Plan covers the following services for mental health treatment:

- **Inpatient** medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.
- Short-term evaluation and crisis intervention mental health services provided on an **outpatient** basis.

Treatment of Alcohol and Drug Abuse

The Plan covers the following services for treatment of alcohol and drug abuse:

- **Inpatient** care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- **Inpatient** medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an appropriately licensed facility.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your PCP.
- **Outpatient** visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.
  Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

Prescription Drugs

The Plan pays, subject to any limitations specified under "Your Benefits," the cost incurred for outpatient prescription drugs that are obtained from a participating pharmacy. You must present your ID card and make the copayment shown in the "Copayment Schedule" for each prescription at the time the prescription is dispensed.

The Plan covers the costs of prescription drugs, in excess of the copayment, that are:

- Medically necessary for the care and treatment of an illness or injury, as determined by Aetna;
- Prescribed in writing by a physician who is licensed to prescribe federal legend prescription drugs or medicines; and
- Not listed under "Prescription Drug Exclusions and Limitations," below.

Each prescription is limited to a maximum 30-day supply, with refills as authorized by your physician (but not to exceed one year from the date originally prescribed). Non-emergency prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name products where permitted by law.

Coverage is based upon Aetna's formulary. The formulary includes both brand-name and generic drugs and is designed to provide access to quality, affordable outpatient prescription drug benefits. You can reduce your copayment by using a covered generic or brand-name drug that appears on the formulary. Your copayment will be highest if your physician prescribes a covered drug that does not appear on the formulary.

Mail Order Drugs

You may obtain up to a 90-day supply of the drug at a participating mail order pharmacy, if authorized by your physician. The copayment shown in the "Copayment Schedule" will apply to each mail order purchase.

Step-Therapy Program

Your pharmacy benefits plan includes Aetna's step-therapy program. Step-therapy is a type of precertification. Under the step-therapy program, certain drugs are not covered unless you have tried one or more "prerequisite therapy" medication(s) first. However, if it is medically necessary for you to use a step-therapy medication as initial therapy without trying a prerequisite therapy drug, your doctor can request coverage of the step-therapy medication as a medical exception by contacting the Pharmacy Management Precertification Unit.

The step-therapy program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, "cost information" includes any manufacturer rebate arrangements between Aetna and the manufacturers of certain drugs on Aetna's Formulary.

The drugs requiring step-therapy are subject to change. Please call Member Services or visit Aetna's website for the current Step-Therapy List.

Precertification

Your pharmacy benefits plan includes Aetna's precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-authorized by Aetna's Pharmacy Management Precertification Unit before they will be covered. Only your physician can request prior authorization for a drug.

The precertification program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, cost information includes any manufacturer rebate arrangements between Aetna and the manufacturers of certain drugs on Aetna's Formulary.

The drugs requiring precertification are subject to change. Call Member Services or visit Aetna's website for the current Precertification List.

Emergency Prescriptions

You may not have access to a participating pharmacy in an emergency or urgent care situation, or if you are travelling outside of the Plan's service area. If you must have a prescription filled in such a situation, the Plan will reimburse you as follows:

Non-Participating Pharmacy

Coverage for items obtained from a non-participating pharmacy is limited to items connected to covered emergency or out-of-area urgent care services. You must pay the pharmacy directly for the cost of the prescription. You are responsible for submitting a written request for reimbursement to Aetna, accompanied by the receipt for the prescription. Aetna will review your request and determine whether the event meets the qualifications for reimbursement. If approved, you will be reimbursed for the cost, minus any applicable copayment.

Participating Pharmacy

When you obtain an emergency or urgent care prescription at a participating pharmacy (including an out-of-area participating pharmacy), you must pay the copay. Aetna will not reimburse you if you submit a claim for a prescription obtained at a participating pharmacy.

Covered Drugs

The Plan covers the following:

- Outpatient prescription drugs when prescribed by a provider who is licensed to prescribe federal legend drugs or medicines, subject to the terms, limitations and exclusions described in this booklet.
- FDA-approved prescription drugs when the off-label use of the drug has not been approved by the FDA to treat the condition in question, provided that:
  - the drug is recognized for treatment of the condition in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or
  - the safety and effectiveness of use for the condition has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.
- Diabetic supplies, as follows:
  - diabetic needles and syringes.
  - alcohol swabs.
  - test strips for glucose monitoring and/or visual reading.
  - diabetic test agents.
  - lancets (and lancing devices).
- Contraceptives and contraceptive devices, as follows:
  - oral contraceptives.
  - one diaphragm per 365-day period.
  - up to 5 vials of Depo-Provera in a 365 consecutive-day period. A separate copayment applies to each vial.
  - Norplant and IUDs are covered when obtained from your PCP or participating Ob/Gyn. The office visit copayment will apply when the device is inserted and removed.

Prescription Drug Exclusions and Limitations

Prescription Drug Exclusions

The following services and supplies are not covered by the Plan, and a medical exception is not available for coverage:

- Any drug that does not, by federal or state law, require a prescription order (such as an over-the-counter drug), even when a prescription is written.
- Any drug that is not medically necessary.
- Charges for the administration or injection of a prescription drug or insulin.
- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth, including (but not limited to) health and beauty aids.
- Any prescription for which the actual charge to you is less than the copayment.
- Any prescription for which no charge is made to you.
- Insulin pumps or tubing for insulin pumps.
- Medication which is to be taken by you or administered to you, in whole or part, while you are a patient in a licensed hospital or similar facility.
- Take-home prescriptions dispensed from a hospital pharmacy upon discharge from the hospital, unless the hospital pharmacy is a participating retail pharmacy.
- Any medication that is consumed or administered at the place where it is dispensed.
- Immunization or immunological agents, including:
  - biological sera.
  - blood, blood plasma or other blood products administered on an outpatient basis.
  - allergy sera and testing materials.
- Drugs used for the purpose of weight reduction, including the treatment of obesity.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Drugs labeled "Caution - Limited by Federal Law to Investigational Use" and experimental drugs.
- Drugs prescribed for uses other than the uses approved by the FDA under the Food, Drug and Cosmetic Law and regulations.
- Medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use.
- Prescription drugs purchased prior to the effective date, or after the termination date, of coverage under this Plan.
- Replacement of lost or stolen prescriptions.
- Drugs used to aid or enhance sexual performance, including (but not limited to):
  - Sildenafil citrate (e.g. Viagra), phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms, and
  - any prescription drug in oral, topical, or any other form that is in a similar or identical class, has a similar or identical mode of action, or exhibits similar or identical outcomes, unless otherwise covered under this plan.

- Performance, athletic performance, or lifestyle-enhancement drugs and supplies.
- Smoking-cessation aids or drugs.
- Growth hormones.
- Test agents and devices, except diabetic test strips.
- Needles and syringes, except diabetic needles and syringes.
- Injectable drugs, except insulin and injectable contraceptives. The Plan does not cover injectable drugs used in the treatment of infertility.

Prescription Drug Limitations

The following limitations apply to the prescription drug coverage:

- A participating retail or mail order pharmacy may refuse to fill a prescription order or refill when, in the professional judgment of the pharmacist, the prescription should not be filled.
- Prescriptions may be filled only at a participating retail or mail order pharmacy, except in the event of emergency or urgent care. Plan participants will not be reimbursed for out-of-pocket prescription purchases from a non-participating pharmacy in non-emergency, non-urgent care situations.
- Plan participants must present their ID cards at the time each prescription is filled to verify coverage. If you do not present your ID card, your purchase may not be covered by the Plan, except in emergency and urgent care situations, and you may be required to pay the entire cost of the prescription.

Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by Aetna.
- Blood, blood plasma, or other blood derivatives or substitutes.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
  - reconstructive surgery to correct the results of an injury.
  - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
  - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
- Custodial care and rest cures.
- Dental care and treatment, including (but not limited to):
  - care, filling, removal or replacement of teeth,
  - dental services related to the gums,
  - apicoectomy (dental root resection),
  - orthodontics,
  - root canal treatment,
  - soft tissue impactions,
  - alveolectomy,
  - augmentation and vestibuloplasty treatment of periodontal disease,
  - prosthetic restoration of dental implants, and

- dental implants.

However, the Plan does cover:

- oral surgery as described under "Your Benefits."

- Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.

  This exclusion will not apply to drugs:

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

  Refer to the "Glossary" for a definition of "experimental or investigational."
- False teeth.
- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids, eyeglasses, or contact lenses or the fitting thereof.
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work.
- Implantable drugs (except as described under "Prescription Drugs").
- Infertility services, except as described under "Your Benefits." The Plan does not cover:
  - purchase of donor sperm and any charges for the storage of sperm.
  - purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
  - cryopreservation and storage of cryopreserved embryos.
  - all charges associated with a gestational carrier program (surrogate parenting) for the Plan participant or the gestational carrier.
  - drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
  - injectable infertility drugs.
  - the costs for home ovulation prediction kits.

- services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.
- services for females with FSH levels greater than 19 mIU/ml on day 3 of the menstrual cycle.

- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips, (except as described under "Prescription Drugs").
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Private duty or special nursing care.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
  - obtaining or continuing employment,
  - obtaining or maintaining any license issued by a municipality, state or federal government,
  - securing insurance coverage,
  - travel, and
  - school admissions or attendance, including examinations required to participate in athletics,

  unless the service is considered to be part of an appropriate schedule of wellness services.
- Services and supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:
  - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,

  - needles, syringes and other injectable aids (except as described under "Prescription Drugs"),
  - drugs related to treatments not covered by the Plan, and
  - drugs related to the treatment of infertility, contraception, and performance-enhancing steroids (except as described under "Prescription Drugs").
- Specific non-standard allergy services and supplies, including (but not limited to):
  - skin titration (wrinkle method),
  - cytotoxicity testing (Bryan's Test),
  - treatment of non-specific candida sensitivity, and
  - urine autoinjections.
- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):
  - primal therapy.
  - chelation therapy.
  - rolfing.
  - psychodrama.
  - megavitamin therapy.
  - purging.
  - bioenergetic therapy.
  - vision perception training.
  - carbon dioxide therapy.
- Thermograms and thermography.
- 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.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under "Your Benefits."
- Treatment of sickness or injury covered by a worker's compensation act or occupational disease law, or by United States Longshoreman's and Harbor Worker's Compensation Act.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
  - treatment performed by placing a prosthesis directly on the teeth,

  - surgical and non-surgical medical and dental services, and
  - diagnostic or therapeutic services related to TMJ.
- Weight reduction programs and dietary supplements.

Limitations

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

In Case of Medical Emergency

Guidelines

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

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

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

Some examples of emergencies are:

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

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

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

Follow-Up Care After Emergencies

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

Urgent Care

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

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

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

Some examples of urgent medical conditions are:

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

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

What to Do Outside Your Aetna Service Area

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

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

Special Programs

Alternative Health Care Programs

Natural Alternatives - If you are interested in alternative therapies such as acupuncture or massage therapy, Aetna has a program to meet your needs. Aetna's Natural Alternatives program offers you special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapists and nutritional counselors.

Vitamin Advantage™ - You can save on vitamins and nutritional supplements purchased through mail order, over the phone, by fax, or over the Internet.

Natural Products - You also can save on many health-related products, including aromatherapy, foot care and natural body care products.

You may place orders by mail, telephone, fax or Internet to receive savings on health-related products offered through these programs.

To Find Out More - Call the Member Services number on your ID card, or visit Aetna on the web at **http://www.aetna.com/products/natural_alt_99.html**. There you can find a listing of participating providers, vendors and the latest additions to the product list. Visit the website often - these programs are growing!

Natural Alternatives is not available in all states.

Fitness Program

Aetna offers Plan participants access to discounted fitness services provided by GlobalFit™. Depending upon your location, you may be eligible for one of two GlobalFit programs.* Under ***GlobalFit A***, Plan participants can join the GlobalFit network and receive discounts on their health club membership rate. Under ***GlobalFit B***, Plan participants can join included clubs directly, receiving the club's lowest corporate rate for the type of membership selected. Both programs offer Plan participants:

- Low or discounted membership rates at independent health clubs contracted with GlobalFit;
- Free guest passes to allow you to sample facilities before selecting a club** to join;
- Guest privileges at other participating GlobalFit health clubs,** and
- Discounts on certain home exercise equipment.

** For current club members, participation under this program may not be available at all clubs.*
***Not available at all clubs.*

To determine which program is offered in your area and to view a list of included clubs, visit the GlobalFit website at **www.globalfit.com/fitness**. If you would like to speak with a GlobalFit representative, you can call the GlobalFit Health Club Help Line at 1-800-298-7800.

Healthy Outlook Program® -- Disease Management for the 21st Century

Aetna has four programs aimed at helping members and their physicians to better manage chronic disease.

Asthma Management Program (pediatric and adult)

The Asthma Management program integrates comprehensive asthma education and instruction in the use of asthma management equipment designed for home use.

Heart Failure Management Program

This program enables patients to receive certain intravenous drugs in the convenience of home and provides education to help them improve their lifestyle and reduce the risk of future hospitalizations.

Diabetes Management Program

The Diabetes Management Program combines member education with blood glucose self monitoring to help achieve better blood sugar control and lessen the chance for the complications of diabetes to develop.

Low Back Pain Disease Management Program

This program provides access to educational materials to help prevent flare-ups of low back pain.

Additional information about Aetna's Disease Management Programs can be found on Aetna's website at **http://www.aetna.com/products/extra/healthy_outlook.html**.

Member Health Education Programs

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

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

Adolescent Immunization

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

Adult Preventive Reminders

Preventive care recommendations can overlap in some cases for people age 50 and older. Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats for people in this age group.

Vaccination programs against diseases such as influenza and pneumococcal pneumonia have been shown to reduce the incidence of illness and death from these diseases.

Aetna sends annual reminders stressing the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screening.

Cancer Screening Programs

Early detection and treatment is important in helping our members lead longer, healthier lives. Member Health Education provides members with an important means of early detection.

Breast Cancer Screening

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease. The mailer may also include information on participating mammography centers or information for women who have chosen a primary care physician with a capitated radiology office.

Cervical

Gynecological examinations and Pap smears are vital to women's health because they are often the first step in the detection and treatment of abnormalities. This program reminds female members, starting at 18 years of age, to get exams and Pap smears on a regular basis. Annually, female members are sent information stressing the importance of annual gynecological exams, direct access to care, as well as instructions on how to perform breast self-examination.

Colorectal

The colorectal cancer cure rate can exceed 80 percent when detected early. We encourage you to discuss questions about colorectal cancer screening with your physician. Together you and your physician can choose the most appropriate method of colorectal cancer screening. Aetna sends annual reminders stressing the importance of completing appropriate colorectal cancer screening.

Childhood Immunization Program

Children need immunizations to protect them from a number of dangerous childhood diseases that could have very serious complications. Vaccines have been proven to be powerful tools for preventing certain diseases. It has been shown over time that the risks of serious illness from not vaccinating children far outweigh any risk of reaction to immunization. The common childhood diseases that vaccinations can guard against are:

- Measles
- Mumps
- Rubella
- Polio
- Pertussis (whooping cough)
- Diphtheria
- Tetanus
- Haemophilus influenzae type B
- Hepatitis B
- Varicella (chicken pox)

To promote good health through prevention, the Childhood Immunization Program sends immunization reminders to parents of children covered under this Plan.

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. This reminder contains a list of immunizations recommended at 18 months.* The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing immunizations.

If you have questions about specific vaccinations, please call your pediatrician or your family doctor.

**Source: Office of Prevention and Health Promotion, in cooperation with the agencies of Public Health Services, U.S. Department of Health and Human Services, Center for Disease Control and Prevention (CDC), American Association of Pediatrics (AAP), and Advisory Committee on Immunization Practices.*

Healthy Breathing® Program

Quitting smoking is one of the biggest steps people can take to improve their health. Millions of people successfully quit smoking each year. That's why Aetna offers the Healthy Breathing Program, which provides access to the GlaxoSmithKline's Committed Quitters® service. The program is available to Plan participants. The program is an 8- to 12-week smoking cessation program that uses nicotine replacement therapy and a personal quit plan to help smokers break their addiction to cigarettes.

Eligible Plan participants who call Member Services using the toll-free telephone number on their Aetna ID card can obtain a brochure that contains a $5 coupon redeemable for the purchase of either a Nicorette® (nicotine gum) or NicoDerm®CQ® (nicotine patch) Starter Kit.* These products can help ease the craving for nicotine and improve the chances of quitting successfully. They are available without a doctor's prescription, although you should discuss use of these products with your physician.

Members can call the 1-800 number in the Starter Kit to begin a quit program or register on line at **www.committedquitters.com**. A personal quit plan usually arrives within a week after calling the 1-800 number. Over the following weeks, members are then sent materials that include information on coping strategies and how to use GlaxoSmithKline's Nicorette or NicoDerm CQ safely and effectively.

If you are an eligible Aetna member, you may call the Member Services number on your Aetna ID card to request the Healthy Breathing brochure.

**Committed Quitters®, Nicorette®, NicoDerm®, and CQ® are registered trademarks owned by and/or licensed to GlaxoSmithKline and are used under license.*

Healthy Eating™ Program

Aetna's *Healthy Eating* booklet provides an easy-to-follow approach to overall better health through good nutrition. The information provides you and your family with tools you can use to develop a healthy eating plan that's realistic. Following a nutritious diet can help you:

- Reduce your risk of illness and disease
- Manage your weight
- Boost your ability to fight illness
- Increase your energy levels
- Look and feel your personal best
- Improve your performance

The *Healthy Eating* booklet outlines the benefits of a healthy diet and how to get started. It's geared toward helping you understand and use the Food Guide Pyramid, read the "Nutrition Facts" labels on most foods, lower the amount of fat you eat, and become more physically active. Sensible weight management is also addressed. The booklet is available to all Plan participants.

Call the Member Services number on your Aetna ID card to request the Healthy Eating booklet.

Healthy Insights Member Newsletter

Aetna periodically publishes the *Healthy Insights* newsletter. The newsletter features health-related information, education about various benefits and issues important to quality management and patient management. *Healthy Insights* is an important resource that communicates with Plan participants about a wide variety of topics.

Informed Health®Line

Informed Health® Line provides eligible Plan participants with telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses encourage informed health care decision making and optimal patient/provider relationships through information and support. However, the nurses do not diagnose, prescribe or give medical advice.
Informed Health Line is available to eligible employees and their families virtually 24 hours per day, 365 days per year from anywhere in the nation.

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

Numbers-to-Know™ -- *Hypertension and Cholesterol Management*

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

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

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

National Medical Excellence Program®

Aetna's National Medical Excellence Program® helps eligible Plan participants access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services.

The program has three components:

- National Transplantation Program, designed to help arrange care for solid organ and bone marrow transplants
- National Special Case Program, developed to coordinate arrangements for treatment of Plan participants with complex conditions at tertiary care facilities across the country when that care is not available within 100 miles of the Plan participant's home
- Out of Country Program, designed for Plan participants who need emergency inpatient medical care while temporarily traveling outside the United States.

If you need a transplant or other specialized care that cannot be provided within the service area, the NME Program will coordinate covered services and will provide the following lodging and travel expenses if you must travel more than 100 miles:

- Transportation expenses you and a companion (if applicable) incur while traveling between your home and the Program facility. Travel expenses incurred by more than one companion are not covered.
- As the NME patient, your lodging expenses incurred while traveling between your home and the National Medical Excellence facility to receive covered services;
- The lodging expenses you incur for lodging away from home to receive covered outpatient services from a NME Program provider;
- The lodging expenses incurred by a companion traveling with you from your home to a National Medical Excellence provider so you can receive covered services; and
- Your companion's lodging expenses when their presence is required to enable you to receive services from a NME Program provider on either an inpatient or outpatient basis. Only the lodging expenses incurred by **one** companion are covered per night.

Benefits for travel and lodging expenses are subject to a maximum of $10,000 per episode of care. Lodging expenses are subject to a $50 per night maximum for each person.

Travel and lodging expenses must be approved in advance by Aetna; if you do not receive approval, the expenses are ***not*** covered.

You become eligible for coverage of travel and lodging expenses on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest to occur of:

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

Travel and lodging expenses do not include expenses that are covered under any other part of the Plan.

The Plan covers only those services, supplies and treatments that are considered necessary for your medical condition. Treatment that is considered experimental (as determined by Aetna) is ***not*** covered by the Plan. Refer to the *Glossary* for a definition of "experimental."

Vision One® Discount Program

Plan participants are eligible to receive discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions through the Vision One program at thousands of locations nationwide. Just call 1-800-793-8616 for information and the location nearest you.

Plan participants are also eligible to receive a discount off the provider's usual retail charge for Lasik surgery (the laser vision corrective procedure) offered by Cole/LCA-Vision LLC through the national Lasik network of LCA Vision, Inc. Included in the discounted price is patient education, an initial screening, the Lasik procedure and follow-up care. To find the closest surgeons, call 1-800-422-6600 and speak to a Lasik customer service representative.

Vision One is a registered trademark of Cole Vision.

Women's Health Care

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

Breast Cancer Case Management

Aetna's breast cancer case management program assists female Plan participants who have been diagnosed with breast cancer in making informed choices for their care. This special educational and support program includes:

- A dedicated breast cancer nurse case manager to answer your questions about coverage, assist with necessary claims authorizations, and facilitate access to treatment by participating specialists and primary care physicians and at participating facilities.
- Educational materials, including *The Wellness Community Guide to Fighting for Recovery From Cancer.*

- Second opinions at participating facilities.

Case Management and Education for Diabetics Considering Pregnancy

Aetna provides diabetic women considering pregnancy with educational materials and nurse case management to help better manage their blood sugar levels prior to pregnancy, which can decrease the chance of delivering babies with birth defects.

Confidential Genetic Testing for Breast and Ovarian Cancers

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

Direct Access for OB/GYN Visits

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

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

Infertility Case Management and Education

Infertility treatment can be an emotional experience for couples. Aetna's infertility case management unit provides Plan participants with educational materials and assistance with coordinating covered infertility care. A dedicated team of registered nurses and infertility coordinators staffs the unit.

Menopause Education

Beginning at age 40, each female Plan participant (who has selected a primary care physician) receives educational information about menopause with her annual mammography reminder. This includes a take-at-home osteoporosis self-evaluation, which she can complete and discuss with her provider.

Moms-to-Babies Maternity Management Program™

The Moms-to-Babies™ maternity management program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Assistance in accessing prenatal care.
- Case management by registered nurses, who will assist in arranging covered services, coordinate covered specialty care, review the program's features and answer general pregnancy-related questions.
- Smoke-free Moms-to-be™, a personalized stop-smoking program designed specifically for pregnant women.
- Focused, educational information, "For Dad or Partner."
- A comprehensive pregnancy handbook.

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

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

Eligibility

Who Is Eligible to Join the Plan

You are eligible to enroll in the Plan if you are a full-time employee of Lee County BoCC, you are regularly scheduled to work 30 or more hours per week and you work or reside in the Plan's service area. Coverage begins on the first of the month following one full month of employment.

When you join the Plan, your spouse and your dependent children are also eligible to join. A dependent child must be unmarried and under the age of 25. Coverage will continue until end of the year in which the child attains age 25.

You may enroll your natural child, foster child, stepchild, legally adopted child, a child under court order, or a grandchild* in your court-ordered custody. Dependents eligible to participate include a lawful spouse, and children, up to the last day of the calendar year in which they attain age 25 if a full-time/part-time student at an accredited school, college or university, and dependent upon the employee for support; or, residing in the household of the employee, and dependent upon the employee for support; each unmarried, natural, adopted from-moment of-placement in the home, step or foster child, and children under court-appointed legal guardianship, who are either (a) full-time or part-time student at an accredited school, college, or university, and dependent upon the employee for support; or, (b) residing in the household of the employee and dependent upon the employee for support. Benefits may be extended for a dependent child who is physically or mentally handicapped.

* A grandchild may be added if the parent is covered as a dependent under the Plan when the child is born. The grandchild may remain covered under the Plan for up to 18 months as long as the parent is a Plan Participant and meets the definition of dependents above.

No person may be covered as both an employee and a dependent under the Plan, and no person may be covered as a dependent of more than one employee.

If Your Child Is Adopted

Coverage for your legally adopted child is effective on the date the child is adopted or placed with you for adoption if you request coverage for the child in writing within 31 days of the placement.

If Your Child Does Not Reside With You

If your child does not live with you, but they live in another Aetna service area, they can choose a PCP in that service area. Your child's coverage under the Plan will then be the same as yours.

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

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

If Your Child Is Handicapped

Unmarried children of any age who are handicapped may also be covered. Your child is handicapped if:

- He or she is not able to earn his or her own living because of a mental or physical disability which started prior to the date he or she reached age 25; and
- He or she depends chiefly on you for support and maintenance.

You must provide proof of your child's handicap no later than 31 days after the child's coverage would otherwise end.

Coverage for a handicapped child ends on the first to occur of the following:

- The child's handicap ceases;
- You fail to provide proof that the handicap continues;
- The child fails to have a required examination by an Aetna participating PCP; or
- The child's coverage as a dependent under the Plan ceases for any reason ***other than*** attainment of the maximum age for dependent coverage.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a court order requiring a parent to provide health care benefits to one or more children. Coverage under the Plan can be extended to a child who is covered by a QMCSO, if:

- The QMCSO is issued on or after the date your coverage becomes effective; and
- Your child meets the definition of an eligible dependent under the Plan; and
- You request coverage for the child within 31 days of the court order.

Coverage will be effective on the date of the court order.

Enrollment

New Employees

When you are first eligible to enroll in the Plan, you will be given enrollment and benefit information, including an enrollment form. You must complete the enrollment form and return it to your Human Resources representative within 31 days of the date you become eligible if you wish to participate in the Plan. If you do not return the form within the 31-day period, Lee County BoCC will assume that you have waived coverage, and you will not be allowed to participate in the Plan until the next open enrollment period, unless you have a change in status.

Open Enrollment

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

Change in Status

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

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

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

Note: Newborn children are automatically covered for 31 days after birth. To continue the coverage beyond 31 days, you must apply by submitting a change form to your Human Resources representative within the 31-day period.

When Coverage Ends

Termination of Employee Coverage

Your coverage will end if:

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

Termination of Dependent Coverage

Coverage for your dependents will end if:

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

Termination for Cause

A Plan participant's coverage may be terminated for cause. "For cause" is defined as:

- **Untenable relationship**: After reasonable efforts, Aetna and/or the Plan's participating providers are unable to establish and maintain a satisfactory provider-patient relationship with you or a Plan participant of your family. You will be given 31 days advance written notice of the termination of coverage.
- **Failure to make copayments**: You or a member of your family fails to make any required copayment or any other payment that you are obligated to pay. You will be given 31 days advance written notice of the termination of coverage.
- **Refusal to provide COB information**: You or a member of your family refuses to cooperate and provide any facts necessary for Aetna to administer the Plan's COB provision. You will be given 31 days advance written notice of the termination of coverage.
- **Furnishing incorrect or incomplete information**: You or a member of your family willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in, or obtaining benefits from, the Plan. Termination will be effective immediately.

- **Fraud against the Plan**: This may include, but is not limited to, allowing a person who is not a participant of the Plan to use your Aetna ID card. Termination will be effective immediately.
- **Misconduct**: You or a covered member of your family abuses the system, including (but not limited to) theft, damage to the property of a participating provider, or forgery of drug prescriptions. Termination will be effective immediately.

No benefits will be provided to you and your family members once coverage is terminated.

Any termination for cause is subject to review in accordance with the Plan's grievance process. You may request that Aetna conduct a grievance hearing within 15 working days after receiving notice that coverage has been or will be terminated. Coverage will be continued until a final decision on the grievance is rendered, provided you continue to make required contributions. Termination may be retroactive to the original date of termination if the final decision is in favor of Aetna.

Family and Medical Leave

If Lee County BoCC grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by Lee County BoCC to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, Lee County BoCC may recover from you the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is terminated because of your gross misconduct, you will not be eligible for COBRA continued coverage.

COBRA Continuation of Coverage

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

Continuation of Coverage Following Termination of Employment or Loss of Eligibility

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

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

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

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

Continuation of Coverage Due to Other Qualifying Events

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

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

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

Applying for COBRA Continuation

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

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

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

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

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

... whichever happens later.

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

When COBRA Continuation Coverage Ends

Continuation coverage will end on the earliest date that:

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

Portability of Coverage

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Lee County BoCC will give you a certificate confirming your participation in the Plan when your employment terminates. Certificates can be obtained from your Human Resources representative.

Coordination of Benefits

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

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

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

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

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

- If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.
- The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.
- If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

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

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

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

Right of Recovery (Subrogation and/or Reimbursement)

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to all rights of recovery a covered Plan participant has against any party potentially responsible for making any payment to that Plan participant due to the Plan participant's injuries or illness, to the full extent of benefits provided or to be provided by the Plan. In addition, if a covered Plan participant receives any payment from any potentially responsible party as a result of an injury or illness, the Plan has the right to recover from, and be reimbursed by, the Plan participant for all amounts this Plan has paid and will pay as a result of that injury or illness, up to and including the full amount the Plan participant receives from all potentially responsible parties. A "covered Plan participant" includes, for the purposes of this provision, anyone on whose behalf the Plan pays or provides any benefit, including (but not limited to) the minor child or dependant of any Plan participant or person entitled to receive any benefits from the Plan.

As used throughout this provision, the term "responsible party" means any party possibly responsible for making any payment to a covered Plan participant due to that Plan participant's injuries or illness or any insurance coverage, including (but not limited to) uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, med-pay coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The covered Plan participant shall do nothing to prejudice the Plan's subrogation and reimbursement rights and shall, when requested, fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the covered Plan participant to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the covered Plan participant.

The covered Plan participant acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties and are to be paid to the Plan before any other claim for the Plan participant's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the covered Plan participant which is insufficient to make the Plan participant whole or to compensate the Plan participant in part or in whole for the damages sustained. It is further agreed that the Plan is not required to participate in or pay attorney fees to the attorney hired by the Plan participant to pursue the covered person's damage claim.

The terms of this entire subrogation and reimbursement provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the covered Plan participant identifies the medical benefits the Plan provided. The Plan is entitled to recover from ***any and all*** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the covered Plan participant and this Plan agree that Aetna shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Claim Procedures

A claim occurs whenever a Plan participant requests:

- An authorization or referral from a participating provider or Aetna; or
- Payment for items or services received.

Because you are a participant in an HMO-type plan, you do not need to submit a claim for most of your covered health care expenses. However, if you receive a bill for covered services, the bill must be submitted promptly to Aetna for payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card.

Aetna will make a decision on your claim. For **concurrent care** claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive notice if Aetna makes an **adverse benefit determination.**

Adverse benefit determinations are decisions Aetna makes that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:
  - it is not included in the list of covered benefits,

- it is specifically excluded,
- a Plan limitation has been reached, or
- it is not medically necessary.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown below. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see "Complaints and Appeals" for more information about appeals.

Type of Claim	Response Time
Urgent care claim: a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care.	15 calendar days
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Urgent care claim - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment. Other claims - 15 calendar days
Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.	With enough advance notice to allow the Plan participant to appeal.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days

Extensions of Time Frames

The time periods described in the chart may be extended.

For urgent care claims: If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided.

For non-urgent pre-service and post service claims: The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Aetna will notify you of the

extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

If an extension is necessary because Aetna needs more information to process your post service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you fail to provide the information, your claim will be denied.

Grievances and Appeals

The Plan has procedures for you to follow if you are dissatisfied with a decision that Aetna has made or with the operation of the Plan. The process depends on the type of complaint you have. There are two categories of complaints:

- Quality of care or operational issues; and
- Adverse benefit determinations.

Complaints about quality of care or operational issues are called grievances. Complaints about adverse benefit determinations are called appeals.

Grievances

Quality of care or operational issues arise if you are dissatisfied with the service received from Aetna or want to complain about a participating provider. To make a complaint about a quality of care or operational issue (called a grievance), call or write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written decision within 30 calendar days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will specify what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

Aetna will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made in writing within 180 days from the date of the notice.

The Plan provides for two levels of appeal plus an option to seek External Review of the adverse benefit determination. You must complete the two levels of appeal before bringing a lawsuit against the Plan. The following chart summarizes some information about how appeals are handled for different types of claims. In certain situations, the time frames shown may be extended.

Type of Claim	Level One Appeal	Level Two Appeal
Urgent care claim: a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.	36 hours Review provided by Appeals Committee.
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care.	15 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	15 calendar days Review provided by Appeals Committee.
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	30 calendar days Review provided by Appeals Committee.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

You and/or an authorized representative may attend the Level 2 appeal hearing and question the representative of Aetna and any other witnesses, and present your case. The hearing will be informal. You may bring your physician or other experts to testify. Aetna also has the right to present witnesses.

If the Level One and Level Two appeals uphold the original adverse benefit determination, you may have the right to pursue an External Review of your claim. See "External Review" for more information.

External Review

You may file a voluntary appeal for external review of any final appeal determination that qualifies.
You must complete the two levels of appeal described above before you can appeal for external review. 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 must request this voluntary level of review within 60 days after you receive the final denial notice.

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.

An external review is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials and denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment. You may request a review by an external review organization (ERO) if:

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

The final claim denial letter you receive 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 60 calendar days of the date you received the final claim denial letter. The form must be accompanied by a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the Request for External Review Form, and will follow the applicable plan's contractual documents and plan criteria governing the benefits. You will generally be notified of the decision of the External Review Organization within 30 days of Aetna's receipt of your request form and all necessary information. An expedited review is available if your physician certifies (by telephone or on a separate Request for External Review

Form) that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within 3-5 calendar days after Aetna receives the request.

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

Claim Fiduciary

Aetna has complete discretionary authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, Aetna has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

Aetna has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. Aetna may not abuse its discretionary authority by acting arbitrarily and capriciously.

Lee County BoCC is responsible for making reports and disclosures required by applicable laws and regulations.

Member Services Department

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

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

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

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

Internet Access

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

When you visit the Member Services site, you can:

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

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

InteliHealth®

InteliHealth is Aetna's online health information affiliate. It was established in 1996 and is one of the most complete consumer health information networks ever assembled. Through this unique program, Plan participants have access, via the Internet, to the wisdom and experience of some of the world's top medical professionals in the field today. Access InteliHealth through the Aetna Internet website home page or directly via **www.intelihealth.com**.

Aetna Navigator™

Aetna Navigator provides a single location for the health and medical issues that matter most to you.

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from InteliHealth®. Access Aetna Navigator™ through the Aetna Internet website home page or directly via **www.aetnanavigator.com**.

When you visit the website, you can see some of Aetna Navigator's distinct features:

- A wealth of health information from InteliHealth, a premier provider of online consumer-based health, wellness and disease-specific information.
- Online customer service functions that allow you to change your primary care physician or primary care dentist, order ID cards and send e-mail inquiries to Member Services.
- Interactive "Cool Tools," including a medical dictionary, allergy and asthma quizzes, a pregnancy due-date calculator and a heart and breath odometer. To access "Cool Tools," look under "Health Tools."
- A preventive care planner that includes recommendations for screenings and immunizations.

Plan participants with certain Aetna plans may also create password-protected Web pages that are personalized to their health care interests. They have access to the features listed above as well as other options including:

- A personal "benefits snapshot" and claims summary.
- DocFind-A-Specialist, Aetna's enhanced online provider directory that helps Plan participants select a specialist based on personal needs and preferences.
- An online survey that allows you to receive customized information based on your personal health interests.

Your Rights and Responsibilities

As a Plan participant, you have a right to:

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

As a Plan participant, you have the responsibility to:

- Choose a PCP from the Plan's network and form an ongoing patient-doctor relationship.
- Help your doctor make decisions about your health care.
- Tell your PCP if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Consult with your PCP for non-emergency referrals to specialist or hospital care.
- See the specialists your PCP refers you to.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Call your PCP before getting care at an emergency facility, unless a delay would be detrimental to your health.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your ID card to providers before getting care from them.
- Pay the copayments and deductibles required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments and what services are covered and what services are not covered.

Patient Self-Determination Act (Advance Directives)

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

What Is an Advance Directive?

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

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

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

What Is a Living Will?

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

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

What Is a Durable Power of Attorney for Health Care?

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

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

Who Decides About My Treatment?

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

How Do I Know What I Want?

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

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

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

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

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

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

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

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

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

Do I Have to Execute an Advance Directive?

No. It is entirely up to you.

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

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

Can I Change My Mind After Writing an Advance Directive?

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

What Is the Plan's Policy Regarding Advance Directives?

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

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

How Can I Get More Information About Advance Directives?

Call the Member Services toll-free number on your ID card. Or, you can call Partnership for Caring at Choice in Dying, a community organization, at 1-800-989-9455.

Federal Notices

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

The Newborns' and Mothers' Health Protection Act

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

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

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For more information, see the section entitled *Precertification and Second Opinions*.

The Women's Health and Cancer Rights Act

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

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

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

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

Plan Information

Amendment or Termination of the Plan

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

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

Plan Documents

This plan description covers the major features of the HMO Plan administered by Aetna Life Insurance Company, effective January 1, 2003.

Glossary

Annual out-of-pocket maximum - means the maximum amount a Plan participant must pay toward covered expenses in a calendar year. Once you reach your annual out-of-pocket maximum, the Plan pays 100% of covered expenses for the remainder of the calendar year. Copays (except prescription drug copays), apply toward the annual out-of-pocket maximum.

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

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

Companion - means a person whose presence as a companion or caregiver is necessary to enable a National Medical Excellence (NME) patient to:

- Receive services from an NME Program provider on an inpatient or outpatient basis; or
- Travel to and from an NME Program provider to receive covered services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed

consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes.

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

Hospice care - means a program of care that is:

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

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

Infertility - means:

- For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.
- For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

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

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

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to

produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;

- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

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

- Information provided on your health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to Aetna's attention.

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

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

Mental or nervous condition - means a condition which manifests signs and/or symptoms that are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited to:

- Psychosis;
- Affective disorders;

- Anxiety disorders;
- Personality disorders;
- Obsessive-compulsive disorders;
- Attention disorders with or without hyperactivity; and
- Other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

NME patient - means a person who:

- Requires any National Medical Excellence procedure or treatment covered by the Plan;
- Is approved by Aetna as an NME patient; and
- Agrees to have the procedure or treatment performed in a facility designated by Aetna as the most appropriate facility.

Outpatient - means:

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

Partial hospitalization - means medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be provided in a hospital or non-hospital facility that is licensed as an alcohol, drug abuse or mental illness treatment program by the appropriate regulatory authority.

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

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

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

Plan participant - means an employee or covered dependent.

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

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

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

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

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

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

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

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

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

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

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