



**What Your Plan
Covers and How
Benefits are Paid**

**Putnam/Northern
Westchester Health
Benefits Consortium**

Plan Document

Form No. PNW-20-1
(Effective January 1, 2020)
NY State Department of Financial Services Approval Pending

Choice POS II Medical Plan

Booklet

Prepared exclusively for:

Employer:	Putnam Northern Westchester Health Benefits Consortium
Agreement number:	100166
Booklet	1
Plan effective date:	January 1, 2020

Third Party Administrative Services provided by Aetna Life Insurance Company

Welcome

This is your booklet. It is one of two documents that together describe the benefits covered by your Employer's self-funded health benefit plan for in-network and out-of-network coverage.

This booklet will tell you about your **covered benefits** – what they are and how you get them. It takes the place of all booklets describing similar coverage that were previously sent to you. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your plan covers only a certain number of visits.

Important Phone Numbers and Addresses

Aetna – Medical and hospital claims administrator

Customer Service: 1-877-223-1685 POSII Plan
1-800-872-3682 Medicare Advantage Plan

To locate an Aetna participating provider:
<http://www.aetna.com/docfind/index.html>
or call Aetna's Customer Service phone number listed above

Medical and hospital claims should be mailed to:
Aetna, Inc.
P.O. Box 981109
El Paso, TX 79998-1109

Navitus Health Solutions – Prescription drug claims administrator

Customer Service Commercial Plan: 1-866-333-2757
Navitus MedicareRx Plan: 1-866-270-3877

Paper claims should be mailed to:
Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999

Putnam/ Northern Westchester Health Benefits Consortium

Office of Risk Management
200 BOCES Drive
Yorktown Heights, NY 10598
914-248-2456

To view a copy of the Plan Document, Summary of Benefits & Coverage, Notices and Newsletters and to download forms:

<http://pnwboces.org/Health-Benefits-Consortium/Health-Benefits-Consortium-Home.aspx>

District Benefits Representatives

Enrollment and eligibility questions and updates should be directed to the District Benefits Representative of your school district

New York State Department of Financial Services

<http://www.dfs.ny.gov/>

New York Department of Financial Services

One Commerce Plaza

Albany, NY 12257

518-474-6600 800-342-3736

PREFACE

The Putnam/Northern Westchester Health Benefits Consortium Health Plan, a Municipal Cooperative Health Benefit Plan, referred to as the Plan, assures covered individuals during the continuance of the Plan that all benefits hereinafter described shall be paid to them, or on their behalf, in the event they incur covered expenses as defined herein. The Plan is subject to all the terms, provisions and limitations stated on the following pages.

This Municipal Cooperative Health Benefit Plan is not a licensed insurer. It operates under a more limited Certificate of Authority granted by the Superintendent of Insurance. Municipal Corporations participating in the Municipal Cooperative Health Benefit Plan are subject to Contingent Assessment Liability.

It is intended that the terms of the Plan be legally enforceable and that the Plan be maintained for the exclusive benefit of eligible employees, retirees and dependents.

The terms of the Plan of benefits are described herein. The eligibility, coverage and benefit provisions, terms and conditions are subject to change with at least 30-days notice.

Whenever the masculine pronoun is used in this document it shall include the feminine gender unless the context clearly indicates otherwise.

Please refer to your Aetna or Navitus identification card for plan/group numbers.

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Schedule of benefits

Issued with your booklet-

Let's get started!

Here are some basics. First things first – some notes on how words are used. It is then explained how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet and the schedule of benefits. And if you need help or more information, you will be told how to reach the Plan.

What your plan does – covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

This plan provides in-network and out-of-network coverage for medical, and in-network pharmacy benefits.

What your plan doesn't do – exclusions

Your plan does not pay for benefits that are not covered under the terms of the plan. These are Exclusions and are described more in greater detail later in the document.

Many health care services and supplies are eligible for coverage under your plan in the *Eligible health services under your plan* section. However, some of those health care services and supplies have exclusions. For example, **physician care** is an eligible health service, but **physician care** for cosmetic surgery is never covered. This is an example of an exclusion.

The *What your plan doesn't cover - some eligible health service exclusions* section of this document also provides additional information.

The Plan does not cover any payments that are prohibited by the Federal Office of Foreign Asset Control.

How your plan works while you are covered in-network

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services. These are called **eligible health services**.
- You will pay less cost share when you use a **network provider**.

1. Eligible health services

Doctor and **hospital** services are the foundation for many other services. You'll probably find the preventive care, **emergency services** and **urgent condition** coverage especially important. But the plan won't always cover the services you want. Sometimes it doesn't cover health care services your doctor will want you to have.

So what are **eligible health services**? They are health care services that meet these three requirements:

- They are listed in the *Eligible health services under your plan* section.
- They are not carved out in the *What your plan doesn't cover – some eligible health service exclusions* section. (The Plan refers to this section as the “exclusions” section.)
- They are not beyond any limits in the schedule of benefits.

2. Providers

Aetna's network of doctors, **hospitals** and other health care **providers** are there to give you the care you

need. You can find **network providers** and see important information about them most easily on Aetna's online **provider directory**. Just log into your Aetna Navigator® secure member website at www.aetna.com.

You may choose a **primary care physician (PCP)** to oversee your care. Your **PCP** will provide your routine care, and send you to other **providers** when you need specialized care. You don't have to access care through your **PCP**. You may go directly to network **specialists** and **providers** for **eligible health services**.

For more information about the network and the role of your **PCP**, see the *Who provides the care* section.

3. **Paying for eligible health services– the general requirements**

There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

- The **eligible health service** is **medically necessary**.
- You get the **eligible health service** from a **network** or **out-of-network provider**.
- You or your **provider** **precertifies** the **eligible health service** when required.

You will find details on **medical necessity** and **precertification** requirements in the *Medical necessity and precertification requirements* section.

4. **Paying for eligible health services– sharing the expense**

Generally the Plan and you will share the expense of your **eligible health services** when you meet the general requirements for paying.

But sometimes the Plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

5. **Disagreements**

We know that people sometimes see things differently. For more information see the *When you disagree - claim decisions and appeals procedures* section.

How your plan works while you are covered out-of-network

The section above told you how your plan works while you are covered in-network. You also have coverage when you want to get your care from **providers** who are not part of the **Aetna** network and from **network providers** without a **provider referral**. It's called out-of-network or **other health care** coverage.

Your out-of-network coverage:

- Means you can get care from **providers** who are not part of the **Aetna** network and from **network providers** without a **provider referral**.
- Means you will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement to Aetna. You are responsible for completing and submitting claim forms for reimbursement of **eligible health services** that you paid directly to a **provider**.
- Means that when you use out-of-network coverage, it is your responsibility to start the **precertification** process with **providers**.
- Means you will pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

- **Precertification** requirements in the *Medical necessity and precertification requirements* section.
- **Out-of-network providers** and any exceptions in the *Who provides the care* section.

- Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

How to contact Aetna for help You can contact Aetna by logging onto your Aetna Navigator® secure member website at www.aetna.com.

Register for Aetna Navigator®, Aetna’s secure internet access to reliable health information, tools and resources. Aetna Navigator® online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can also contact Aetna by:

- Calling **Aetna** Member Services at the toll-free number on your ID card
- Writing Aetna at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Your member ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this plan. Show your ID card each time you get health care from a **provider** to help them bill Aetna correctly and help Aetna better process their claims.

Remember, only you and your covered dependents can use your member ID card. If you misuse your card the Plan may end your coverage.

Aetna will mail you your ID card. If you haven’t received it before you need **eligible health services**, or if you’ve lost it, you can print a temporary ID card. Just log into your Aetna Navigator® secure member website at www.aetna.com.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Waiting Period
- Open Enrollment
- Employee Eligibility
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is Eligible

Your "Employer" as defined in the "Glossary" section, decides who is eligible for health care coverage.

When you can join the plan

As an employee you can enroll yourself and your dependents:

- At the end of any waiting period your Employer requires
- During your Employer's annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself and your dependents when you first qualify for health benefits, you may have to wait until the next annual enrollment period to join.

Waiting Period

You and your Dependents (see Glossary) are eligible for coverage as specified under "Waiting Period" in the "Glossary" section.

Open Enrollment Period

Certain provisions of your Open Enrollment Period may be modified by your Employer. If you have Open Enrollment Period questions, contact your School District's business or personnel office.

Each component employer may allow eligible employees to enter the Plan during an annual open enrollment period. This period shall be from November 1 through November 30 and become effective the following January 1, unless the employer has notified the Consortium that an alternate time period has been selected and has been communicated to its employees.

An individual entering the Plan during the open enrollment period shall not be considered a late enrollee.

Employee Eligibility

Minimum requirements for determination of eligibility shall be established by each individual Employer subject to the following:

An individual who is employed by more than one participating employer shall only be allowed to enroll under one employer.

Employee Coverage

If an employee submits a completed enrollment application to the Employer's HR Department within 31-days of the date of FIRST eligibility, the employee's coverage may become effective on the first day of the month following the month in which the employee applies for coverage.

- A. If an employee requests that coverage begin on the first date of employment, the employer may, at its discretion, comply with the employee's request provided the employee submits a completed enrollment application to the Employer's HR Department on or before the date of employment.
- B. The participating employer may, at its discretion, also require the employee to satisfy a period of employment before coverage for the employee and any eligible dependents becomes effective; however, this employment period must be applied on a uniform basis for all new employees and may not exceed ninety (90) days. The effective date of coverage will be the first day of the month following the month during which the employee satisfies the required period of employment. An employee who is hired on, or otherwise acquires eligibility on, the first day of a month may count that month in establishing his effective date of coverage.

An employee who fails to submit a completed enrollment application to the Employer's HR Department for enrollment during the 31-day period following the date of his first eligibility must then wait for the annual enrollment period to apply for coverage.

Who can be on your plan (who can be your dependent)

You can enroll the following family members on your plan. They are referred to in this booklet as your "Dependents". Subject to all conditions of the term "Dependent" as defined in the "Glossary" section, the following section provides additional guidance:

- A. Spouse means an individual to whom the employee is legally married, as recognized in New York State
- B. A natural, adopted or step-child under age 26 is eligible for coverage. A child under age 26 who is not the natural, adopted or step-child of the employee may be covered if s/he is claimed as a dependent in accordance with section 152(f) of the Internal Revenue Code
- C. Time spent in service with a branch of the United States military, not to exceed 4 years, may be deducted from the age of a child in determining his eligibility for enrollment.
- D. A handicapped child as defined under "Dependent" in the "Glossary" section.
- E. Any person who does not specifically meet one of the criteria outlined in this section shall not be an eligible dependent.
- F. Any person who is on active duty in the armed forces of any country shall not be an eligible dependent

Adding New Dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
 - Your Employer must receive your completed enrollment information not more than 31 days after the date of your marriage.
 - Ask your Employer when benefits for your spouse will begin. If the employee requests that dependent coverage begin on the date of marriage, the employer shall comply with the employee's request provided he/she submits a completed enrollment application to the Employer's HR Department on or before the date of marriage.
 - No later than the first day of the first calendar month after the date your Employer receives your completed enrollment information and
 - Within 31 days of the date of your marriage.
- A newborn child - Your newborn child is covered on your health plan for the first 48 hours for a vaginal delivery or 96 hours for C-section even if the baby is not added to the plan within the required 60 days.
 - To keep your newborn covered, your Employer's HR Department must receive your completed

- enrollment information within 60 days of birth.
- You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional contribution for the covered dependent.
- An adopted child -
 - Your Employer's HR Department must receive your completed enrollment information within 60 days after the adoption.
- A stepchild - You may put a child of your spouse on your plan.
 - You must complete your enrollment information and send it to your Employer's HR Department within 31 days after the date of your marriage with your stepchild's parent.
 - Ask your Employer when benefits for your stepchild will begin. It is either on the date of your marriage or the first day of the month following the date we receive your completed enrollment information.

Dependent Coverage

This section shall not apply to adult children who are enrolling pursuant to the NY State "Age 29" Law.

- A. If an employee applies for Family coverage at the same time as Individual coverage, the effective date of Family coverage will be the same as the employee's.
- B. If an employee submits a completed enrollment application to the Employer's HR Department to add a dependent within 31-days of the date an eligible dependent is first acquired, the effective date of coverage for that dependent will be the first day of the month following the month in which the completed enrollment application is received by the employer's HR Department.. If the completed enrollment application is submitted on the first day of the month and is within 31-days of acquiring the dependent, then coverage may become effective that day.
 - a. If this change is due to marriage and the employee requests that dependent coverage begin on the date of marriage, the employer shall comply with the employee's request provided he submits a completed enrollment application to the Employer's HR Department on or before the date of marriage.
 - b. If this change is due to the birth or adoption of a child and the employee requests that coverage begin on the date of birth or adoption, the employer shall comply with the employee's request provided he submits a completed enrollment application to the Employer's HR Department within 60-days of the date of birth or adoption.
- C. If an employee who has only Individual coverage submits a completed enrollment application to the Employer's HR Department to add a dependent more than 31-days after the acquisition of the eligible dependent (60-days following the birth or adoption of a child), then the employee must wait until the annual enrollment period to add the dependent however, if the new dependent is a newborn infant and the employee did not submit a completed enrollment application to the Employer's HR Department within 60-days, then coverage shall become effective from the date the employee submits a completed enrollment application to the Employer's HR Department.
- D. If an employee who has Family coverage submits a completed enrollment application to the Employer's HR Department to add an additional dependent more than 31-days after acquisition of the new dependent (60-days following the birth or adoption of a child), coverage shall become effective no earlier than the first day of the calendar month following the month in which the employee submits a completed enrollment application to the Employer's HR Department; however, if the new dependent is a newborn infant and the employee did not submit a completed enrollment application to the Employer's HR Department within 60-days, then coverage shall become effective from the date the employee submits a completed enrollment application to the Employer's HR Department

Changes from Family Coverage

- A. An enrollee may change from Family coverage to Individual coverage at any time. Adjustment of the employer's and employee's contribution toward the cost of coverage shall not take effect until the first day of the month following the month of the request to change to Individual coverage.
- B. If, and only if, the sole dependent of an enrollee is also an eligible employee or retiree of a participating employer, but not already covered as an employee or retiree, Family coverage may be changed to two Individual coverages. This coverage change shall take effect on the first day of the month following the month of the change request.
- C. If the spouse of an employee enrolled for Family coverage is also an employee or retiree of a participating employer, but not already covered as an employee or retiree, enrollment may be transferred from the currently enrolled spouse to the dependent spouse only during the annual, open enrollment period.

Eligibility for Retiree Benefits

- A. An employee or retiree of a participating employer is eligible to continue coverage in retirement if he:
 - a. has had at least ten (10) years of full-time service, not necessarily continuous, with the employer from which he is retiring; (In the event that an employer's collective bargaining agreement, internal policy or past practice differs from 10-years, it shall take precedence over this provision of the Plan Document). and
 - b. has vested for benefits from a retirement system administered by the State of New York; and
 - c. is at least 55 years of age.
- B. An employee or retiree is also eligible to continue coverage during retirement, regardless of age or length of service with the participating employer, if granted a service connected disability retirement by a retirement or pension plan or system administered and operated by the State of New York due to an injury, illness or disease that resulted from his service with the participating employer.
- C. Employees who have qualified for Social Security Disability payments are considered to be retired for health benefits purposes, regardless of age, provided that they have had at least 10 years of service with the participating employer. Proof of Social Security status will be required.

Vesting for Benefits

- A. Employees who terminate their employment before age (55) may continue their health benefits if they have;
 - a. satisfied the minimum requirements established by their retirement system for vesting receipt of their retirement allowance (this need not be done officially); and
 - b. met the minimum requirements of the employer, other than age, for continuation of health benefits into retirement; and
 - c. terminated employment within five (5) years of the date on which they
 - i. are entitled to receive a retirement allowance or
 - ii. (b) become age fifty five (55).
- B. Eligible employees who wish to continue coverage as enrollees in the program during vested status, must pay both the employer and employee share of the cost of coverage (i.e. the full cost of coverage) from the date their employment terminates until the date they become eligible to receive a retirement allowance from an approved retirement system. After that date, they are only responsible for the retiree's share of payments, if any. All required payments by vestees must be made to the employer where they were formerly employed.
- C. Vestees, who wish to continue coverage into their retirement, must continue health insurance coverage as an enrollee or as a dependent of an enrollee while in vested status. This may include coverage as the spouse of an enrollee of a participating employer different than that of the vestee. Further, if the vestee maintains continuity of coverage as a dependent of an enrollee, he may continue vestee status beyond that date that he initially becomes eligible to receive a retirement allowance from an approved

retirement system. **A vestee whose coverage lapses will not be permitted to reinstate coverage, either during vested status or after retirement.**

- D. Once an employee has established eligibility to continue health benefits coverage as a vestee through one participating employer, that eligibility shall not be impaired by subsequent employment and/or enrollment through another participating employer, except when the employee establishes eligibility for coverage as a vestee or retiree through the second, or subsequent employer.

Notification of change in status

It is important that you notify your Employer's HR Department of any changes in your benefit status. This will help your Employer effectively maintain your benefit status. Please notify your Employer as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other group health plan of any covered dependent

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
 - You were covered by another group health plan, and now that other coverage has ended.
 - You had COBRA, and now that coverage has ended.
 - You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your contribution for coverage under this plan.

Your Employer's HR Department must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Declination of Health Benefits

Except as noted below, an individual who declines coverage at the time he initially becomes eligible or declines coverage during the annual enrollment period, shall be required to wait until the next Open Enrollment Period Effective Date to become covered under the Plan. This shall include, but not be limited to, an employee who declines coverage in favor of an employee's "buy out" option or to avoid paying the employee's share of the health benefits premium.

Certain changes in your status may enable you to enroll in the Plan at times other than the annual open enrollment period. Where an employee, retiree or dependent rejected initial enrollment in the Plan, he may later enroll if each of the following conditions are met:

The employee, retiree or dependent was covered under another plan at the time coverage was initially offered, and;

Eligibility for coverage under the other plan was lost and coverage was terminated for one of the following reasons:

- continuation coverage required by Federal or State law was exhausted; or
- termination of employment; or
- death of the spouse; or
- legal separation, divorce or annulment; or
- reduction in the number of hours of employment; or
- contract holder (e.g. employer) contributions toward the payment of premium for the other plan were terminated; or
- reaching the maximum eligibility age.

A completed enrollment application must be submitted to the Employer's HR Department within 31-days of termination to be considered timely.

Medical necessity and precertification requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services**. See the *Eligible health services under your plan* and *exclusions* sections plus the schedule of benefits.

Your plan pays for its share of the expense for **eligible health services** only if the general requirements are met. They are:

- The **eligible health service** is **medically necessary**.
- You or your **provider precertifies** the **eligible health service** when required.

This section addresses the **medical necessity** and **precertification** requirements.

Medically necessary; medical necessity

As stated in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are stated in the *Glossary* section, where the plan define "**Medically necessary/Medical necessity**". That is where it explains what Aetna's medical directors or their **physician** designees consider when determining if an **eligible health service** is **medically necessary**.

Precertification

You need pre-approval from Aetna for some **eligible health services**. Pre-approval is also called **precertification**.

In-network: your **physician** is responsible for obtaining any necessary **precertification** before you get the care. If your **physician** doesn't get a required **precertification**, Aetna won't pay the **provider** who gives you the care. You won't have to pay either if your **physician** fails to ask Aetna for **precertification**. If your **physician** requests **precertification** and it is refused, you can still get the care but the plan won't pay for it. You will find details on requirements in the *What the plan pays and what you pay - Important exceptions – when you pay all* section.

Out-of-network: when you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from Aetna for any services and supplies on the **precertification** list. If you do not **precertify**, your benefits may be reduced, or the plan may not pay any benefits. Refer to your schedule of benefits for this information. The list of services and supplies requiring **precertification** appears later in this section. Also, for any **precertification** benefit reduction that is applied see the schedule of benefits *Precertification benefit reduction* section.

When it is a life-threatening emergency, call 911 or go straight to the nearest emergency room. If admitted, **precertification** should be secured within the timeframes specified below. To obtain **precertification**, call Aetna at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
For an emergency admission :	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.

For an urgent admission :	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness , the diagnosis of an illness , or an injury .
For outpatient non-emergency medical services requiring precertification :	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your **physician** of the **precertification** decision, where required by state law. If your **precertified** services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

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

If **precertification** determines that the **stay** or services and supplies are not **covered benefits**, the notification will explain why and how Aetna’s decision can be appealed. You or your **provider** may request a review of the **precertification** decision. See the *Claim decisions and appeals procedures* section.

Precertification covered benefit reduction
This only applies to out-of-network coverage. The booklet contains a complete description of the precertification program. You will find details on precertification requirements in the <i>Medical necessity and precertification requirements</i> section.
Failure to precertify your eligible health services when required will result in the following benefits reduction: <ul style="list-style-type: none"> • A reduced payment percentage of 50% of benefits otherwise payable or \$250, whichever is less, will apply separately to the covered benefit provided for each eligible health service or • The eligible health services will not be covered.
The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain precertification is not a covered benefit , and will not be applied to the deductible amount or the maximum out-of-pocket limit , if any.

What types of services require precertification?

Precertification is required for the following types of services and supplies:

Inpatient services and supplies
Stays in a hospital
Stays in a skilled nursing facility
Stays in a rehabilitation facility
Stays in a hospice facility
Stays in a residential treatment facility for treatment of mental disorders and substance abuse
Bariatric surgery (obesity)
Comprehensive infertility services
Cosmetic and reconstructive surgery

Certain **prescription drugs** are covered under the medical plan when they are given to you by your doctor or health care facility and not obtained at a **pharmacy**. The following **precertification** information applies to these **prescription drugs**:

For certain drugs, your **prescriber** or your pharmacist needs to get approval before Aetna will agree to cover the drug for you. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs and makes sure there is a **medically necessary** need for the drug. For the most up-to-date information, call the toll-free Member Services number on your member ID card or log on to your Aetna Navigator® secure member website at www.aetna.com.

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where Aetna requires you to first try certain drugs to treat your medical condition before they will cover another drug for that condition.

You can obtain the most up-to-date information about **step therapy prescription drugs** by calling the toll-free Member Services number on your member ID card or by logging on to your Aetna Navigator® secure member website at www.aetna.com. Your doctor can find additional details about the **step therapy prescription drugs** in Aetna's clinical policy bulletins.

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not covered or for which health care services are denied through **precertification and/or step therapy**. You or your **prescriber** can contact Aetna and will need to provide them with the required clinical documentation. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case determination, and will not apply or extend to other covered persons.

Eligible health services under your plan

The information in this section is the first step to understanding your plan's **eligible health services**.

Your plan covers many kinds of health care services and supplies, such as **physician** care and **hospital stays**. But sometimes those services are not covered at all or are covered only up to a limit.

For example,

- **Physician** care generally is covered but **physician** care for **cosmetic** surgery is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about these exclusions in the *exclusions* section, and about the limitations in the schedule of benefits.

The health care services are grouped below to make it easier for you to find what you're looking for.

Preventive care and wellness

This section describes the **eligible health services** and supplies available under your plan when you are well.

Important notes:

1. You will see references to the following recommendations and guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- United States Preventive Services Task Force
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.

3. Gender-specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your Aetna Navigator® secure member website at www.aetna.com or at the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

Routine physical exams

Eligible health services include office visits to your **physician, PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness or injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - Screening and counseling services on topics such as:
 - Interpersonal and domestic violence
 - Sexually transmitted diseases
 - Human Immune Deficiency Virus (HIV) infections
 - Screening for gestational diabetes for women
 - High risk Human Papillomavirus (HPV) DNA testing for women 30 and older
- Radiological services, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** checkup.

Preventive care immunizations

Eligible health services include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician, PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes pap smears and routine chlamydia screening tests. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness or injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

Bone Mineral Density Measurements or Testing

The Plan covers bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Booklet. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for

osteoporosis.

The Plan also covers bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by Health Resources and Services Administration (HRSA) and items or services with an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF).

This benefit is not subject to Copayments, Deductibles or Payment Percentage when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

Preventive screening and counseling services

Eligible health services include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

- **Obesity and/or healthy diet counseling**
Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
 - Preventive counseling visits and/or risk factor reduction intervention
 - Nutritional counseling
 - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**
Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
 - Preventive counseling visits
 - Risk factor reduction intervention
 - A structured assessment

- **Use of tobacco products**
Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:
 - Preventive counseling visits
 - Treatment visits
 - Class visits;
 - Tobacco cessation prescription and over-the-counter drugs
 - **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Tobacco product means a substance containing tobacco or nicotine such as:

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**
Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.
- **Genetic risk counseling for breast and ovarian cancer**
Eligible health services include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

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

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

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a **network provider** who is an OB, GYN or OB/GYN.

Prenatal care

Eligible health services include your routine prenatal physical exams as *Preventive Care*, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You can get this care at your **physician's, PCP's, OB's, GYN's, or OB/GYN's** office.

Important note:

You should review the benefit under *Eligible health services under your plan- Maternity and related newborn care* and the *exclusions* sections of this booklet for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

Breast feeding durable medical equipment

Eligible health services include renting or buying **durable medical equipment** you need to pump and store breast milk as follows:

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**.
- The buying of:
 - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every three years, or
 - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

Breast pump supplies and accessories

Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

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

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

Eligible health services include counseling services provided by a **physician**, **PCP**, **OB**, **GYN**, or **OB/GYN** on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices

Eligible health services include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a **physician** during an office visit.

Voluntary sterilization

Eligible health services include charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note:

See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs*
- *Treatment of basic infertility*

Physicians and other health professionals

Physician services

Eligible Health Services include services by Your Physician to treat an Illness or Injury. You can get those services:

- At the Physician's office
- In Your home
- In a Hospital
- From any other inpatient or outpatient facility
- By way of Telemedicine – Teladoc is the only telemedicine provider covered under the plan.

Important note:

The plan covers Telemedicine only when you get your consult through a Provider that has contracted with Aetna to offer these services.

All in person office visits covered with a Behavioral Health Provider are also covered if you use Telemedicine instead.

Telemedicine may have different cost sharing. See the Schedule of Benefits for more information.

Other services and supplies that Your Physician may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests

Physician surgical services

Eligible health services include the services of:

- The surgeon who performs your **surgery**
- Your surgeon who you visit before and after the **surgery**
- Another surgeon who you go to for a second opinion before the **surgery**

Important note:

Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician** services and not for a separate fee for facilities.

Alternatives to physician office visits

Walk-in clinic

Eligible health services include health care services provided in **walk-in clinics** for:

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license

Hospital and other facility care

Hospital care

Eligible health services include inpatient and outpatient **hospital** care.

The types of **hospital** care services that are eligible for coverage include:

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians** employed by the **hospital**.
- Operating and recovery rooms.
- Intensive or special care units of a **hospital**.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a **hospital**.

Alternatives to hospital stays

Outpatient surgery and physician surgical services

Eligible health services include services provided and supplies used in connection with outpatient **surgery** performed in a **surgery center** or a **hospital's** outpatient department.

Important note:

Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician or PCP** services and not for a separate fee for facilities.

Home health care

Eligible health services include home health care provided by a **home health care agency** in the home, but only when all of the following criteria are met:

- You are homebound.
- Your **physician** orders them.
- The services take the place of your needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home.
- The services are a part of a **home health care plan**.
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.
- If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.
- Home health aide services are provided under the supervision of a registered nurse.
- Medical social services are provided by or supervised by a **physician** or social worker.

Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. See the *Short-term rehabilitation services and Habilitation therapy services* sections and the schedule of benefits.

Home health care services do not include **custodial care**.

Hospice care

Eligible health services include inpatient and outpatient **hospice care** when given as part of a **hospice care program**.

The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital**
- Bereavement counseling
- Respite care

Hospice care services provided by the **providers** below may be covered, even if the **providers** are not an employee of the **hospice care agency** responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
 - Physical and occupational therapy
 - Medical supplies
 - Outpatient **prescription drugs**
 - Psychological counseling
 - Dietary counseling

Outpatient private duty nursing

Eligible health services include private duty nursing care provided by an **R.N.** or **L.P.N.** for non-hospitalized acute **illness** or **injury** if your condition requires skilled nursing care and visiting nursing care is not adequate. If a Covered Person incurs medically necessary expenses which are recommended and approved by a Physician for private-duty nursing services outside of a hospital, the Plan shall pay for such private-duty nursing charges not exceeding the maximum amount specified in the Schedule of Benefits for such charges. Private-duty nursing services shall be payable only if provided by a Registered Nurse (R.N.). If the services of an R.N. are not available, a Licensed Vocational Nurse (L.V.N.) or a Licensed Practical Nurse (L.P.N.) or a Registered Nurse Midwife acting within the scope of his license.

Skilled nursing facility

Eligible health services include inpatient **skilled nursing facility** care.

The types of **skilled nursing facility** care services that are eligible for coverage include:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies that are provided during your **stay** in a **skilled nursing facility**

Conditions for Skilled Nursing Facility Care

The Plan will pay for care in a Skilled Nursing Facility described below when the following conditions are met:

- a. Care in a skilled nursing facility must be medically necessary. Care is medically necessary when it must be furnished by skilled personnel to assure the safety of the patient and achieve the medically desired result. Custodial care is not covered. In order to determine whether care is

medically necessary, the guidelines used by the Federal government's Medicare program will be applied. The Managed Benefits Program Coordinator, in conference with the patient's Physician, will verify medical necessity and establish when skilled nursing facility care is appropriate and eligible for benefits.

- b. Coverage will only be provided for as long as in-patient hospital care would have been required if care in a skilled nursing facility were not provided.

Kind of Skilled Nursing Facility

The facility must be either:

- a. accredited as a skilled nursing facility by the Joint Commission on Accreditation of Hospitals; or
- b. certified as a participating skilled nursing facility under Medicare.

Covered Services

The Plan will pay the charges of a skilled nursing facility for:

- a. a semi-private room (if a private room is occupied, the Plan will pay an amount equal to the facility's most common charge for a semi-private room);
- b. physical, occupational and speech therapy;
- c. medical social services;
- d. drugs, biologicals, supplies, appliances and equipment furnished for use in the facility and which are ordinarily provided by the facility to patients; and
- e. other services necessary for the patient's health which are generally provided by the facility.

Emergency services and urgent care

Eligible health services include services and supplies for the treatment of an **emergency medical condition** or an **urgent condition**.

As always, you can get emergency care from **network providers**. However, you can also get emergency care from **out-of-network providers**.

Your coverage for **emergency services** and urgent care from **out-of-network providers** ends when **Aetna** and the attending **physician** determine that you are medically able to travel or to be transported to a **network provider** if you need more care.

As it applies to in-network coverage, you are covered for follow-up care only when your **physician or PCP** provides or coordinates it. If you use an **out-of-network provider** to receive follow up care, you are subject to a higher out-of-pocket expense.

In case of a medical emergency

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your **physician or PCP** but only if a delay will not harm your health.

Non-emergency condition

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the *exclusion –Emergency services and urgent care and Precertification covered benefit reduction* sections and the schedule of benefits for specific plan details.

In case of an urgent condition

Urgent condition

If you need care for an **urgent condition**, you should first seek care through your **physician or PCP**. If your **physician or PCP** is not reasonably available to provide services, you may access urgent care from an **urgent care facility**.

Non-urgent care

If you go to an **urgent care facility** for what is not an **urgent condition**, the plan may not cover your expenses. See the *exclusion –Emergency services and urgent care and Precertification covered benefit reduction* sections and the schedule of benefits for specific plan details.

Specific conditions

Autism spectrum disorder

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

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

We will cover certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That is responsible for observable improvements in behavior.

Important note:

Applied behavior analysis requires **precertification** by **Aetna**. The **network provider** is responsible for obtaining **precertification**. You are responsible for obtaining **precertification** if you are using an **out-of-network provider**.

Birthing center

Eligible health services include prenatal and postpartum care and obstetrical services from your **provider**. After your child is born, **eligible health services** include:

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Diabetic equipment, supplies and education

Eligible health services include:

- Services and supplies
 - Foot care to minimize the risk of infection
 - Insulin preparations
 - Injection aids for the blind
 - Diabetic test agents
- Equipment
 - External insulin pumps

- Training
 - Self-management training provided by a health care **provider** certified in diabetes self-management training

This coverage is for the treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.

Family planning services – other

Eligible health services include certain family planning services provided by your **physician** such as:

- Voluntary sterilization for males
- Abortion

Maternity and related newborn care

The Plan covers services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. The Plan covers prenatal care (including one visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the New York Public Health Law. The Plan will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Booklet for coverage of inpatient maternity care.

The Plan covers the cost of renting or the purchase of one breast pump per pregnancy for the duration of breast feeding.

Coverage also includes the services and supplies needed for circumcision by a Provider.

Mental health treatment

Eligible health services include the treatment of **mental disorders** provided by a **hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital or residential treatment facility**, including:
 - Office visits to a **physician or behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
 - Individual, group and family therapies for the treatment of mental health
 - Other outpatient mental health treatment such as:
 - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**
 - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**
 - Skilled behavioral health services provided in the home, but only when all the following criteria are met:
 - You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
 - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications

- Electro-convulsive therapy (ECT)
- Mental health injectables
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- 23 hour observation

Substance related disorders treatment

Eligible health services include the treatment of **substance abuse** provided by a **hospital, psychiatric hospital, residential treatment facility, physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate** and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**.

As used here, “medical complications” include, but are not limited to, **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital** or **residential treatment facility**, including:
 - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**.
 - **Intensive Outpatient Program** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**.
 - Ambulatory detoxifications which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications.
 - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor.

Important note:

Please refer to the *Physicians and other health professionals* section for information about **eligible health services** for **e-visits** and **telemedicine** consultations.

Obesity surgery

Eligible health services include obesity surgery, which is also known as “weight loss surgery.” Obesity surgery is a type of procedure performed on people who are **morbidly obese**, for the purpose of losing weight.

Obesity is typically diagnosed based on your **body mass index (BMI)**. To determine whether you qualify for obesity surgery, your doctor will consider your **BMI** and any other condition or conditions you may have. In general, obesity surgery will not be approved for any member with a **BMI** less than 35.

Your doctor will request approval in advance of your obesity surgery. The plan will cover charges made by a **network provider** for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription drug** benefits included under the *Outpatient prescription drugs* section

Health care services include one obesity surgical procedure. However, **eligible health services** also include a multi-stage procedure when planned and approved by the plan. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

You may go to any of our **network** facilities that perform obesity surgeries.

Oral Surgery (mouth, jaws and teeth)

The Plan covers the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental Injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the Injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

Reconstructive surgery and supplies

Eligible health services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema and prostheses.
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
 - The defect results in severe facial disfigurement or major functional impairment of a body part.
 - The purpose of the **surgery** is to improve function.
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Transplant services

Eligible health services include organ transplant services provided by a **physician** and **hospital**.

Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

Network of transplant specialist facilities

The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need
- A Non-IOE facility

The National Medical Excellence Program® will coordinate all solid organ and bone marrow transplants, and other specialized care you need.

Treatment of infertility

Basic infertility

Eligible health services include seeing a **network provider**:

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.
- Coverage shall not include diagnosis or treatment in connection with in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers, the reversal of sterilization, sex change procedures, cloning or procedures or services that are experimental.
- Coverage is limited to individuals whose ages range from twenty-one (21) through forty-four (44), and whose diagnosis and treatment has been prescribed as part of a physician's overall plan of care.

Comprehensive infertility services

Eligible health services include comprehensive **infertility** care. The first step to using your comprehensive infertility health care services is enrolling with Aetna's National Infertility Unit (NIU). To enroll you can reach the dedicated NIU at 1-800-575-5999.

Infertility services

You are eligible for **infertility** services if:

- You are covered under this plan as an employee or as a covered dependent who is the employee's legal spouse, referred to as "your partner".
- There exists a condition that:
 - Is demonstrated to cause the disease of **infertility**.
 - Has been recognized by your **physician** or **infertility specialist** and documented in your or your partner's medical records.
- You or your partner has not had a voluntary sterilization, with or without surgical reversal, regardless of post reversal results.
This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You or your partner does not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have met the requirement for the number of months trying to conceive through egg and sperm contact.
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the Aetna's medically necessary criteria

The NIU is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators with expertise in all areas of **infertility** who can help:

- Enroll in the **infertility** program.
- Assist you with **precertification** of **eligible health services**.
- Coordinate **precertification** for comprehensive infertility when these services are **eligible health services**.
- Evaluate your medical records to determine whether comprehensive **infertility** services are reasonably likely to result in success.

- Determine whether comprehensive **infertility** services are **eligible health services**.

Your **provider** will request approval from Aetna in advance for your **infertility** services. The Plan will cover charges made by an **infertility specialist** for the following **infertility** services:

- Ovulation induction cycle(s) with menotropins.
- Intrauterine insemination.
- Advanced Reproductive Technology (ART)

A “cycle” is an attempt at ovulation induction or intrauterine insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

Advanced reproductive technology (ART)

Advanced reproductive technology (ART), also called “assisted reproductive technology”, is a more advanced type of **infertility** treatment. **Covered services** include the following services provided by an ART **specialist**:

- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)

ART **covered services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan. For plans with cycle limits, an ART “cycle” is defined as:

Procedure	Cycle count
One complete fresh IVF cycle with transfer (egg retrieval, fertilization, and transfer of embryo)	One full cycle
One fresh IVF cycle with attempted egg aspiration (with or without egg retrieval) but without transfer of embryo	One-half cycle
Fertilization of egg and transfer of embryo	One-half cycle
One cryopreserved (frozen) embryo transfer	One-half cycle
One complete GIFT cycle	One full cycle
One complete ZIFT cycle	One full cycle

You are eligible for ART services if:

- You or your partner have been diagnosed with **infertility**
- You have exhausted comprehensive **infertility** services benefits or have a clinical need to move on to ART procedures
- You have met the requirement for the number of months trying to conceive through egg and sperm contact
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna’s **infertility** clinical policy

Aetna's National Infertility Unit

The first step to using your ART **covered services** is enrolling with our National Infertility Unit (NIU). Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators. They can help you with determining eligibility for benefits and can give you information about our **infertility** Institutes of Excellence™ facilities. They can also help your **provider** with **precertification**. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your **infertility** services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned services that are proven to result in **infertility** such as:
 - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
 - Other gonadotoxic therapies
 - Removing the uterus
 - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna's **infertility** clinical policy.

Premature ovarian insufficiency

If your **infertility** has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

The following are not **covered services**:

- Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm or reproductive tissue.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
 - Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when a successful pregnancy could have been obtained through less costly treatment.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- **Infertility** treatment when **infertility** is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period.
- Treatment for dependent children, except for fertility preservation as described above.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a **provider**, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including Positron emission tomography (PET) scans
- Other outpatient diagnostic imaging service where the billed charge exceeds \$500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

Chemotherapy

Eligible health services for chemotherapy depends on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Outpatient infusion therapy

Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **physician** in the office
- A home care **provider** in your home

Infusion therapy is the parenteral (e.g. intravenous) administration of prescribed medications or solutions.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable **home health care** maximums.

Outpatient radiation therapy

Eligible health services include the following radiology services provided by a **health professional**:

- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Specialty prescription drugs

Eligible health services include **specialty prescription drugs** when they are:

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

You can access the list of **specialty prescription drugs** by contacting Aetna Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this booklet.

When injectable or infused services and supplies are provided in your home, they will not count toward any applicable **home health care** maximums.

Short-term cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Eligible health services include cardiac rehabilitation services you receive at a **hospital, skilled nursing facility or physician's office**, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

Eligible health services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if it is part of a treatment plan ordered by your **physician**.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a **hospital, skilled nursing facility, or physician's office**, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living.

Eligible health services include short-term rehabilitation services your **physician** prescribes. The services have to be performed by:

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

- A **physician**

Short-term rehabilitation services have to follow a specific treatment plan.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness, injury or surgical procedure**.
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
 - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness, injury or surgical procedure**, or
 - Relearn skills so you can significantly improve your ability to perform the activities of daily living.
- Speech therapy, but only if it is expected to:
 - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness, injury or surgical procedure**, or
 - Improve delays in speech function development caused by a gross anatomical defect present at birth.

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

- Cognitive rehabilitation associated with physical rehabilitation, but only when:
 - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
 - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Habilitation therapy services

Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

Eligible health services include habilitation therapy services your **physician** prescribes. The services have to be performed by:

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

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to develop any impaired function.
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development.
(Speech function is the ability to express thoughts, speak words and form sentences).

Telemedicine Program – The Plan covers online internet or phone consultations between You and Providers who participate in the Teladoc program for medical conditions that are not an Emergency Condition.

<p>General Medicine: Members can receive treatment within minutes for non-emergency, acute general needs such as:</p>	<p>Dermatology: Members can request a dermatology consult for complex or ongoing conditions such as:</p>	<p>Behavioral Health: Members can receive support for such issues as:</p>
<ul style="list-style-type: none"> • Flu • Cough • Sinus Problems • Sore throat • Allergies • Sunburn • Bronchitis • Ear Infection • Arthritis • Pink eye 	<ul style="list-style-type: none"> • Rash • Psoriasis • Rosacea • Acne • Skin Infections 	<ul style="list-style-type: none"> • Stress • Anxiety • Depression

To get started:

1. You can set up an account by the following:
 - Online: Go to [Teladoc.com/Aetna](https://teladoc.com/Aetna) and click “set up account”
 - Mobile App: Download the app at teladoc.com/mobile and click “activate account”
 - Call Teladoc: Teladoc can help you register your account at 1-855-Teladoc (835-2362)
2. Provide Medical History
 - Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.
3. Request a Consult
 - Once your account is set up, request a consult anytime you need care. Talk to a doctor by phone, web, or mobile app.

Teladoc is the only telemedicine provider covered under the plan. Telemedicine services billed by any other provider (e.g. CareMount) will not be covered under the plan.

Other services

Acupuncture

Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your **physician**, if the service is performed:

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

Ambulance service

Eligible health services include transport by professional ground **ambulance** services:

- To the first **hospital** to provide **emergency services**.
- From one **hospital** to another **hospital** if the first **hospital** cannot provide the **emergency services** you need.
- From a **hospital** to your home or to another facility if an **ambulance** is the only safe way to transport you.
- From your home to a **hospital** if an **ambulance** is the only safe way to transport you. Transport is limited to 100 miles.

Your plan also covers transportation to a **hospital** by professional air or water **ambulance** when:

- Professional ground **ambulance** transportation is not available.
- Your condition is unstable, and requires medical supervision and rapid transport.
- You are travelling from one **hospital** to another and
 - The first **hospital** cannot provide the **emergency services** you need, and
 - The two conditions above are met.

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when you have cancer or terminal illnesses and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- Aetna determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

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

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred by you from a **provider** in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network.

Dialysis coverage

The Plan covers dialysis treatments of an acute or chronic kidney ailment.

The Plan also covers dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Aetna in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that Aetna has a reasonable opportunity to review Your travel and treatment plans.
- Aetna has the right to Preauthorize the dialysis treatment and schedule.
- Aetna will provide benefits for no more than 10 dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount Aetna would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying **DME** and accessories you need to operate the item from a **DME** supplier. Your plan will cover either buying or renting the item, depending on which is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

Your plan only covers the same type of **DME** that Medicare covers. But there are some **DME** items Medicare covers that your plan does not. Examples of those are listed in the *exclusions* section.

Hearing aids and exams

Eligible health services include hearing care that includes hearing exams, prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired human hearing
- Parts, attachments, or accessories

Hearing aid services are:

- Audiometric hearing exam and evaluation for a hearing aid **prescription** performed by:
 - A **physician** certified as an otolaryngologist or otologist
 - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select and adjust or fit a hearing aid

Nutritional supplements

Eligible health services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Prosthetic devices

Eligible health services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Prosthetic device means:

- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of **illness** or **injury** or congenital defects.

Coverage includes:

- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Instruction and other services (such as attachment or insertion) so you can properly use the device

Spinal manipulation

Eligible health services include spinal manipulation to correct a muscular or skeletal problem, but only if your **provider** establishes or approves a treatment plan that details the treatment, and specifies frequency and duration.

Exclusions: What your plan doesn't cover

Now you already know about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. And you were told, that some of those health care services and supplies have exclusions. For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.

This section will talk about the exclusions. They are grouped to make it easier for you to find what you want.

- Under "General exclusions" it explained what general services and supplies are not covered under the entire plan.
- Below the general exclusions, in "Exclusions under specific types of care," it explained what services and supplies are exceptions under specific types of care or conditions.

Please look under both categories to make sure you understand what exclusions may apply in your situation.

And just a reminder, you'll find coverage limitations in the schedule of benefits.

General exclusions

Aviation

The Plan does not cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors.
- Any related services including processing, storage or replacement expenses.
- The services of blood donors, apheresis or plasmapheresis.

For autologous blood donations, only administration and processing expenses are covered.

Convalescent and Custodial Care

The Plan does not cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

Conversion Therapy

The Plan does not cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

Cosmetic services and plastic surgery

- Any treatment, **surgery (cosmetic or plastic)**, service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This cosmetic services exclusion does not apply to **surgery** after an accidental **injury** when performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected.

Counseling

- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling.

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Dental care except as covered in the *Eligible health services under your plan* Oral and maxillofacial treatment section.

Dental services related to:

- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Bony impacted teeth
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

This exclusion does not include bone fractures, removal of tumors, and odontogenic cysts

Early intensive behavioral interventions

Examples of those services are:

- Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions.

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, wilderness treatment program, job training and job hardening programs
- Services provided by a school district.

Examinations

Any health examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a law requires it.
- To buy coverage or to get or keep a license.
- To travel.

- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (**experimental or investigational**) or covered under clinical trials (routine patient costs). See the *Eligible health services under your plan – Other services* section.

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Felony Participation.

The Plan does not cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

Foot care

The Plan does not cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, the Plan will cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

Growth/height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures**, devices and growth hormones to stimulate growth

Jaw joint disorder

- Non-surgical treatment of Temporomandibular joint disorder (TMJ)
- Temporomandibular joint disorder treatment (TMJ) performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
 - Sheaths
 - Bags
 - Elastic garments
 - Support hose
 - Bandages
 - Bedpans
 - Syringes
 - Blood or urine testing supplies
 - Other home test kits
 - Splints
 - Neck braces
 - Compresses
 - Other devices not intended for reuse by another patient

Medically Necessary.

In general, The Plan will not cover any health care service, procedure, treatment, test, device or Prescription Drug that Aetna or Navitus determines is not Medically Necessary. If an External Appeal Agent certified by the State overturns the denial, however, the Plan will cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise covered under the terms of this Booklet.

Medicare or Other Governmental Program.

The Plan does not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, Aetna will reduce the Plan benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if the Plan is required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

Military Service.

The Plan does not cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance.

The Plan does not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

Outpatient prescription or non-prescription drugs and medicines

- Outpatient **prescription** or non-**prescription drugs** and medicines provided by the employer or through a third party vendor contract with the employer.

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party.

Pregnancy charges

- Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses as specifically described in the *Eligible health services under your plan* section

Routine exams

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan* section

Services Not Listed.

The Plan does not cover services that are not listed in this Booklet as being covered.

Services provided by a family member

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

Services with No Charge

The Plan does not cover services for which no charge is normally made.

Services Separately Billed by Hospital Employees

The Plan does not cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Sex change

- Any treatment, drug, service or supply related to changing sex or sexual characteristics.
Examples of these are:
 - **Surgical procedures** to alter the appearance or function of the body
 - Hormones and hormone therapy
 - Prosthetic devices

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
 - **Surgery, prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
 - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
 - Strength
 - Physical condition
 - Endurance
 - Physical performance

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
 - Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
 - Hypnosis and other therapies
 - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
 - Nicotine patches
 - Gum

Treatment in a federal, state, or governmental entity

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Vision care

- Vision care services and supplies, including:
 - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and
 - Laser in-situ keratomileusis (LASIK), including related procedures designed to surgically correct refractive errors

War

The Plan does not cover an illness, treatment or medical condition due to war, declared or undeclared.

Wilderness treatment programs

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

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "non-occupational" regardless of cause.

Additional exclusions for specific types of care

Preventive care and wellness

- Services for diagnosis or treatment of a suspected or identified **illness** or **injury**
- Exams given during your **stay** for medical care
- Services not given by or under a **physician's** direction
- Psychiatric, psychological, personality or emotional testing or exams

Family planning services

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the **provider** or were not the primary purpose of a confinement.

Physicians and other health professionals

There are no additional exclusions specific to **physicians** and other **health professionals**.

Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services

- The services of any other **physician** who helps the operating **physician**
- A **stay** in a **hospital** (**Hospital stays** are covered in the *Eligible health services under your plan – Hospital and other facility care* section.)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Home health care

- Services for infusion therapy
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling. This includes estate planning and the drafting of a will
- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
 - Sitter or companion services for either you or other family members
 - Transportation
 - Maintenance of the house

Outpatient private duty nursing

(See home health care in the *Eligible health services under your plan and Outpatient and inpatient skilled nursing care* sections regarding coverage of nursing services).

Specific conditions

Family planning services - other

- Reversal of voluntary sterilization procedures including related follow-up care
- Family planning services received while confined as an inpatient in a **hospital** or other facility

Maternity and related newborn care

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries.

Mental health treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association):
 - Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
 - Sexual deviations and disorders except for gender identity disorders
 - Tobacco use disorders, except as described in the *Eligible health services under your plan – Preventive care and wellness* section
 - Pathological gambling, kleptomania, pyromania
 - School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
 - Services provided in conjunction with school, vocation, work or recreational activities
 - Transportation

Obesity (bariatric) surgery

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity** except as described in the *Eligible health services under your plan – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions.. This is regardless of the existence of other medical conditions. Examples of these are:
 - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**
 - **Surgical procedures**, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**
 - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
 - Hypnosis or other forms of therapy
 - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Transplant services

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing **illness**
- Harvesting and/or storage of bone marrow, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing **illness**

Specific therapies and tests

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Specialty prescription drugs

- **Specialty prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer.
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan.

Short-term rehabilitation services

Outpatient cognitive rehabilitation, physical, occupational and speech therapy

- Except for physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
 - Autism Spectrum Disorder
 - Down syndrome
 - Cerebral palsy
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**.
- Services provided by a **physician**, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits have been paid under the spinal manipulation section.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.
- Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth.

Other services

Ambulance services

- Fixed wing air ambulance from an **out-of-network provider**

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section.

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the

- clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Hearing aids and exams

The following services or supplies:

- A replacement of:
 - A hearing aid that is lost, stolen or broken
 - A hearing aid installed within the prior 12 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**
- Any tests, appliances and devices to:
 - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
 - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

Nutritional supplements

- Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Other services* section.

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Outpatient prescription drugs

Preventive Contraceptives

- **Brand-name prescription drug** forms of contraception in each of the methods identified by the FDA

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible health services**, the foundation for getting covered care is the network. This section tells you about **network** and **out-of-network providers**.

Network providers

Aetna has contracted with **providers** to provide **eligible health services** to you. These **providers** make up the network for your plan. For you to receive the network level of benefits you must use **network providers** for **eligible health services**. There are some exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section
- **Urgent care** – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section

You may select a **network provider** from the **directory** through your Aetna Navigator® secure member website at www.aetna.com. You can search Aetna's online **directory**, DocFind®, for names and locations of **providers**.

You will not have to submit claims for treatment received from **network providers**. Your **network provider** will take care of that for you. And **Aetna** will directly pay the **network provider** for what the plan owes.

Your PCP

You are encouraged to access **eligible health services** through a **PCP**. They will provide you with primary care.

A **PCP** can be any of the following **providers** available under your plan:

- General practitioner
- Family physician
- Internist
- Pediatrician
- OB, GYN, and OB/GYN

How do you choose your PCP?

You can choose a **PCP** from the list of **PCPs** in Aetna's **directory**. See the *Who provides the care, Network providers* section.

Each covered family member is encouraged to select their own **PCP**. You may each select your own **PCP**. You should select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What will your PCP do for you?

Your **PCP** will coordinate your medical care or may provide treatment. They may send you to other **network providers**.

Your **PCP** can also:

- Order lab tests and radiological services.
- Prescribe medicine or therapy.
- Arrange a **hospital stay** or a **stay** in another facility.

How do I change my PCP?

You may change your **PCP** at any time. You can call Aetna at the toll-free number on your ID card or log on to your Aetna Navigator® secure member website at www.aetna.com to make a change.

Out-of-network providers

You also have access to **out-of-network providers**. This means you can receive **eligible health services** from an **out-of-network provider**. If you use an **out-of-network provider** to receive **eligible health services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network **deductible**
- Your out-of-network **payment percentage**
- Any charges over our **recognized charge**
- Submitting your own claims and getting **precertification**

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network.
- You are already a member of **Aetna** and your **provider** stops being in Aetna's network.

However, in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

	If you are a new enrollee and your provider is an out-of-network provider	When your provider stops participation with Aetna
Request for approval	You need to complete a Transition Coverage Request form and send it to Aetna. You can get this form by calling the toll-free number on your ID card.	You or your provider should call Aetna for approval to continue any care.
Length of transitional period	Care will continue during a transitional, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the provider terminated their participation with Aetna .

If you are pregnant and have entered your second trimester, the transitional period will include the time required for postpartum care directly related to the delivery.

Aetna will authorize coverage for the transitional period only if the **provider** agrees to their usual terms and conditions for contracting **providers**.

What the plan pays and what you pay

Who pays for your **eligible health services** – this plan, both, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **deductible**
- Your **copayments/payment percentage**
- Your **maximum out-of-pocket limit**

You are reminded that sometimes you will be responsible for paying the entire bill: for example, if you get care that is not an **eligible health service**.

The general rule

When you get **eligible health services**:

- You pay for the entire expense up to any **deductible** limit.

And then

- The plan and you share the expense up to any **maximum out-of-pocket limit**. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment/ payment percentage**.

And then

- The plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

“Expense” in this general rule, means the **negotiated charge** for a **network provider**, and the **recognized charge** for an **out-of-network provider**. See the *Glossary* section for what these terms mean.

Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all **eligible health services** under the preventive care and wellness benefit.

Important exceptions – when you pay all

You pay the entire expense for an **eligible health service**:

- When you get a health care service or supply that is not **medically necessary**. See the *Medical necessity, and precertification requirements* section.
- When your plan requires **precertification**, your **physician** requested it, the plan refused it, and you get an **eligible health service** without **precertification**. See the *Medical necessity, and precertification requirements* section.

In all these cases, the **provider** may require you to pay the entire charge. Any amount you pay will not count towards your **maximum out-of-pocket limit**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor the Plan are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge**

Where your schedule of benefits fits in

How your deductible works

Your **deductible** is the amount you need to pay, after paying your **copayment** or **payment percentage**, for **eligible health services** per Calendar Year as listed in the schedule of benefits. Your **copayment** or **payment percentage** does not count toward your **deductible**.

How your copayment/ payment percentage works

Your **copayment/payment percentage** is the amount you pay for **eligible health services**. Your schedule of benefits shows you which **copayments/ payment percentage** you need to pay for specific **eligible health services**.

You will pay the **physician, PCP copayment/payment percentage** when you receive **eligible health services** from any **PCP**.

How your maximum out-of-pocket limit works

You will pay your **deductible** and **copayments/payment percentage** up to the **maximum out-of-pocket limit** for your plan. Your schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered benefits** for the remainder of that **Calendar Year**.

Important note:

See the schedule of benefits for any **deductibles, copayments/ payment percentage, maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions that may apply.

Claim Decisions and Appeals Procedures

When you disagree - Claim Determinations, Grievance and Appeals procedures

A Health Plan member is entitled to know why a claim has been denied or partially paid.

When you receive a denial or a partial payment for a claim which you believe should have been paid differently, you should do the following:

- Review your Benefits Plan Booklet.
- Call the claims administrator using the applicable toll-free numbers shown on your ID Cards.
- Discuss the paragraphs from the Plan Booklet pertaining to the coverage denied with the claims processing representative.

Most denied or partially paid claims are resolved to the member's satisfaction by reviewing the Plan Booklet and the facts of the claim. Claims that may have been initially processed inappropriately are usually either corrected by this point or the situation is more fully explained to the claimant by the claims processing representative at the claims administrator

Send your **appeal** to the Claims Administrator's Customer Service Department at the following address, or call in your **appeal** to Customer Service using the toll-free telephone number.

Aetna, Inc.
P.O. Box 981106
El Paso, TX 79998-1106
1-877-223-1685

Navitus Health Solutions
Appeal Supporting Documentation
Request
P.O. Box 999
Appleton, WI 54912-0999
1-866-333-2757
Fax: 1-855-673-6507

Claim Determinations

A. Claims

A claim is a request that benefits or services be provided or paid according to the terms of this Booklet. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Aetna. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Aetna. See the Coordination of Benefits section of this Booklet for information on how benefit payments are coordinated when You also have group health coverage with another plan.

B. Notice of Claim

Claims for services must include all information designated by Aetna as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Aetna by calling Member Services at the number on Your ID card or visiting Aetna's website at www.aetna.com. Completed claim forms should be sent to the address on Your ID

card. You may also submit a claim to Aetna electronically by sending it to the e-mail address on Your ID card or visiting Aetna's website at www.aetna.com.

C. Timeframe for Filing Claims

Claims for services must be submitted to Aetna for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days period, You must submit it as soon as reasonably possible. Initial claims submitted more than 15-months after the date of service will be denied.

D. Claims for Prohibited Referrals

The Plan and Aetna are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations

Aetna's claim determination procedure applies to all claims that do not relate to a Medical Necessity or Experimental or Investigational determination. For example, Aetna's claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Aetna's claim determination, You may submit a Grievance pursuant to the Grievance section of this Booklet.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or Experimental or Investigational determinations, see the Utilization Review and External Appeal sections of this Booklet.

F. Pre-Service Claim Determinations

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If Aetna has all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), they will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If Aetna needs additional information, they will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If Aetna receives the information within 45 days, they will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Aetna's receipt of the information. If all necessary information is not received within 45 days, they will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if Aetna has all information necessary to make a determination, Aetna will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If Aetna needs additional information, they will request it within 24 hours. You will then have 48 hours to submit the information. Aetna will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Aetna's receipt of the information or the end of the 48-hour time period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations

A post-service claim is a request for a service or treatment that You have already received. If Aetna has all information necessary to make a determination regarding a post-service claim, they will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If Aetna needs additional information, they will request it within 30 calendar days. You will then have 45 calendar days to provide the

information. Aetna will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Aetna's receipt of the information or the end of the 45 day period.

Grievance Procedures

A. Grievances

The Grievance procedure applies to any issue not relating to a Medical Necessity or Experimental or Investigational determination by Aetna. For example, it applies to contractual benefit denials or issues or concerns You have regarding Aetna's administrative policies or access to Providers.

B. Filing a Grievance

You can contact Aetna by phone at the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. Aetna may require that You sign a written acknowledgement of Your oral Grievance, prepared by Aetna. You or Your designee has up to 180 calendar days from when You received the decision You are asking Aetna to review to file the Grievance.

When Aetna receives Your Grievance, they will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

All requests and discussions are kept confidential and Aetna will take no discriminatory action because of Your issue. Aetna has a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. Aetna will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:

By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances:

In writing, within 15 calendar days of receipt of (A request for a service or Your Grievance for treatment that has not yet been provided.)

Post-Service Grievances:

In writing, within 30 calendar days of receipt of (A claim for a service or Your Grievance for treatment that has already been provided.)

All Other Grievances:

In writing, within 30 calendar days of receipt (That are not in relation of Your Grievance to a claim or request for a service or treatment.)

D. Grievance Appeals

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card, in person, or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When Aetna receives Your Appeal, they will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. Aetna will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:

The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances:

15 calendar days of receipt of Your Appeal. (A request for a service or a treatment that has not yet been provided.)

Post-Service Grievances:

30 calendar days of receipt of Your Appeal. (A claim for a service or a treatment that has already been provided.)

All Other Grievances:

30 business days of receipt of all necessary (That are not in relation information to make a determination to a claim or request for a service or treatment.)

E. Assistance

If You remain dissatisfied with Aetna's Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

Utilization Review

Aetna reviews health services to determine whether the services are or were Medically Necessary or Experimental or Investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. Aetna does not compensate or provide financial incentives to their employees or reviewers for determining that services are not Medically Necessary. Aetna has developed guidelines and protocols to assist them in this process. For substance use disorder treatment, Aetna will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for Your review upon request. For more information, call Aetna Member Services at the number on Your ID card or visit Aetna's website at www.aetna.com.

Preauthorization Reviews

1. **Non-Urgent Preauthorization Reviews.** If Aetna has all the information necessary to make a determination regarding a Preauthorization review, Aetna will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

If Aetna needs additional information, they will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If Aetna receives the requested information within 45 days, they will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Aetna's receipt of the information. If all necessary information is not received within 45 days, Aetna will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if Aetna has all information necessary to make a determination, they will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If Aetna needs additional information, they will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. Aetna will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Aetna's receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of Aetna's receipt of the information or three (3) calendar days after the verbal notification.
3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, Aetna will make a determination and provide notice to You (or Your designee) or Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Aetna's receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

Concurrent Reviews

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) or Your Provider, by

telephone and in writing, within one (1) business day of receipt of all necessary information. If Aetna needs additional information, they will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. Aetna will make a determination and provide notice to You (or Your designee) or Your Provider, by telephone and in writing, within one (1) business day of Aetna's receipt of the information or, if they do not receive the information, within 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of Urgent Care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, Aetna will make a determination and provide notice to You (or Your designee) or Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and Aetna has all the information necessary to make a determination, Aetna will make a determination and provide written notice to You (or Your designee) or Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If Aetna needs additional information, they will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. Aetna will make a determination and provide written notice to You (or Your designee) or Your Provider within the earlier of one (1) business day or 48 hours of Aetna's receipt of the information or, if they do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, Aetna will make a determination and provide notice to You (or Your designee) or Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, Aetna will make a determination and provide notice to You (or Your designee) or Your Provider within 72 hours of receipt of the necessary information. When Aetna receives a request for home care services and all necessary information prior to Your discharge from an inpatient Hospital admission, Aetna will not deny coverage for home care services while Aetna's decision on the request is pending.
4. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Aetna at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, Aetna will make a determination within 24 hours of receipt of the request and they will provide coverage for the inpatient substance use disorder treatment while Aetna's determination is pending.
5. **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a Participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OASAS-certified Facility notifies Aetna of both the admission and the initial treatment plan within 48 hours of the admission. After the first 14 days of the inpatient admission, Aetna may review the entire stay to determine whether it is Medically Necessary. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

Retrospective Reviews

If Aetna has all information necessary to make a determination regarding a retrospective claim, they will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If Aetna needs additional information, they will request it within 30 calendar days. You or Your Provider will then have

45 calendar days to provide the information. Aetna will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Aetna's receipt of the information or the end of the 45-day period.

Once Aetna has all the information to make a decision, Aetna's failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

Retrospective Review of Preauthorized Services

Aetna may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Aetna upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Aetna upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Aetna;
- Aetna was not aware of the existence of such information at the time of the Preauthorization review; and
- Had Aetna been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

Reconsideration

If Aetna did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider in writing.

Utilization Review Internal Appeals

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. Aetna will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when Aetna determines that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
 - a. A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the

- alternate health service available from a Participating Provider that Aetna approved to treat Your condition; and
- b. Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.
2. **Out-of-Network Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when Aetna determines that they have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
- a. That the Participating Provider recommended by Aetna does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
 - b. Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

Appeals

First Level Appeal

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, Aetna will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.
2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, Aetna will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.
3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

Aetna's failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Substance Use Appeal

If Aetna denies a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or your Provider file an expedited internal Appeal of Aetna's adverse determination, Aetna will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Aetna's adverse determination, Aetna will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

Second Level Appeal

If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external appeal. **The four (4) month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external Appeal.**

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. Aetna will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and inform You, if necessary, of any additional information needed before a decision can be made.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, Aetna will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.
2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, Aetna will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.
3. **Expedited Appeal.** If Your Appeal relates to an urgent matter, Aetna will decide the Appeal and provide written notice of the determination to You (or Your designee), and where appropriate, Your Provider, within 72 hours of receipt of the Appeal request.

Appeal Assistance

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

External Appeals

Your Right to an External Appeal

In some cases, You have a right to an external appeal of a denial of coverage. If Aetna has denied coverage on the basis that a service does not meet Aetna's requirements for Medical Necessity (including appropriateness, health care setting, level of care or effectiveness of a Covered Benefit); or is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two requirements:

1. The service, procedure, or treatment must otherwise be a Covered Service under the Booklet; and
2. In general, You must have received a final adverse determination through the first level of Aetna's internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
 - a. Aetna agrees in writing to waive the internal Appeal. Aetna is not required to agree to Your request to waive the internal Appeal; or
 - b. You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - c. Aetna fails to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and Aetna demonstrates that the violation was for good cause or due to matters beyond Aetna's control and the violation occurred during an ongoing, good faith exchange of information between You and Aetna).

Your Right to Appeal a Determination that a Service is Not Medically Necessary

If Aetna has denied coverage on the basis that the service does not meet Aetna's requirements for Medical Necessity, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph above.

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If Aetna has denied coverage on the basis that the service is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two requirements for an external appeal in paragraph above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; **or**
2. There does not exist a more beneficial standard service or procedure Covered by Aetna; **or**
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); **or**
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); **or**
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

Your Right to Appeal a Determination that a Service is Out-of-Network

If Aetna has denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two requirements for an external appeal in paragraph above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

You do not have a right to an external appeal for a denial of a Referral to an out-of-network Provider on the basis that a health care Provider is available in-network to provide the particular health service requested by You.

Your Right to Appeal an Out-of-Network Referral Denial

If Aetna has denied coverage of a request for a Referral to a Non-Participating Provider because Aetna determined they have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two requirements for an external appeal in paragraph above.

In addition, Your attending Physician must: certify that The Participating Provider recommended by Aetna does not have the appropriate training and experience to meet Your particular health care needs; and recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

The External Appeal Process

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Aetna's failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

Aetna will provide an external appeal application with the final adverse determination issued through the first level of Aetna's internal Appeal process or their written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which Aetna based their denial, the External Appeal Agent will share this information with Aetna in order for them to exercise their right to reconsider their decision. If Aetna chooses to exercise this right, Aetna will have three (3) business days to amend or confirm their decision. Please note that in the case of an expedited external appeal (described below), Aetna do not have a right to reconsider their decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Aetna. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued Stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Aetna by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Aetna's decision that a service is not Medically Necessary or approves coverage of an Experimental or Investigational treatment, Aetna will provide coverage subject to the other terms and conditions of this Booklet. Please note that if the External Appeal Agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, Aetna will only Cover the cost of services required to provide treatment to You according to the design of the trial. Aetna will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Booklet for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and the Plan. The External Appeal Agent's decision is admissible in any court proceeding.

You will be charged a fee of \$25 for each external appeal, not to exceed \$75 in a single Plan Year. The external appeal application will explain how to submit the fee. The fee will be waived if it is determined that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

Your Responsibilities

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Aetna's failure to adhere to claim processing requirements. The Plan has no authority to extend this deadline.

Joint Governance Board

If your complaint or grievance has not been resolved, you may submit it to the Joint Governance Board for review. **Please note that the Joint Governance Board will NOT address Adverse Benefit Determinations.**

Submit all documentation that you wish to be reviewed by the Joint Governance Board, **within 60 days after receipt of the notice of determination.** The Board will review your complaint or grievance at a regularly scheduled meeting and render a decision. The decision will be communicated to you, in writing within 15 days. Documentation should be submitted to:

Joint Governance Board
Attn: Office of Risk Management
Putnam/ Northern Westchester Health Benefits Consortium
200 BOCES Drive
Yorktown Heights, NY 10598

If you are not satisfied with the Joint Governance Board's decision you may request a hearing before the Board.

- a. Your request for a hearing must be made in writing to the Joint Governance Board **within 60 days from the date of notice of the Joint Governance Board's decision.**
- b. The Board will determine if your request for a hearing will be granted. If granted, the Board will set a hearing date.
 1. Your complaint or grievance should be presented to the Board at the hearing by you and/or your personal representative.
 2. The Board will review all materials submitted through the hearing process and will provide you with a written response as to its determination within 15 days. That determination is final.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms

Here are some key terms used in this section. These terms will help you understand this *COB* section.

Allowable expense means:

- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic surgery** generally is not an allowable expense under this plan.

In this section when it's talked about a "plan" through which you may have other coverage for health care expenses, it means:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here's how COB works

- When this is the primary plan, Aetna will pay your medical claims first as if the other plan does not exist.
- When this plan is secondary to another plan that is primary, Aetna will first calculate the benefit AS IF THIS PLAN WAS PRIMARY. The benefit will then be reduced by the amount paid by the other plan. This method of coordination is referred to as Maintenance of Benefits.

The Plan will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or Dependent	The plan covering you as an employee or retired employee.	The plan covering you as a dependent.
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: <ul style="list-style-type: none">• Online: Log on to your Aetna Navigator® secure member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans.	

	<ul style="list-style-type: none"> • By phone: Call the toll-free Member Services number on your ID card. 	
COB rules for dependent children		
Child of: <ul style="list-style-type: none"> • Parents who are married or living together 	The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: <ul style="list-style-type: none"> • Parents separated or divorced or not living together • With court-order 	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse’s plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse’s plan is primary.
Child of: <ul style="list-style-type: none"> • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody 	Primary and secondary coverage is based on the birthday rule.	
Child of: <ul style="list-style-type: none"> • Parents separated or divorced or not living together and there is no court-order 	The order of benefit payments is: <ul style="list-style-type: none"> • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last 	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	<p>When this plan is secondary to another plan that is primary, benefits will first be calculated <u>AS IF THIS PLAN WAS PRIMARY. The benefit will then be reduced by the amount paid by the other plan.</u> This method of coordination is referred to as Maintenance of Benefits.</p> <p>The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.</p>

How COB works with Medicare

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

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

You are eligible for Medicare when you are covered under it by reason of:

- Age, disability, or
- End stage renal disease

You are also eligible for Medicare even if you are not covered if you:

- Refused it
- Dropped it, or
- Did not make a proper request for it

When you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. In the case of someone who is eligible but not covered, the plan may pay as if you are covered by Medicare and coordinates benefits with the benefits Medicare would have paid had you enrolled in Medicare. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	Primary plan	Secondary plan
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan

If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months.	Medicare
	Medicare will pay first after this 30 month period.	Your plan
A disability other than ESRD and you are still actively employed with the School District	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is primary	We calculate the amount we would pay if there were no Medicare coverage. If the Medicare payment is equal to or more than what we would pay, we make no payment. If Medicare paid less than what we would pay, we pay the difference between our payment and the Medicare payment.

EFFECTS OF MEDICARE

Most Medicare eligible members covered by the Consortium will be enrolled in the Consortium's Medicare Advantage plan (Medicare Part C) provided by Aetna and the Medicare Prescription Drug Plan (Medicare Part D) provided by Navitus. Members enrolled in the Medicare Advantage medical plan/Medicare drug plan should refer to separate plan documents provided by Aetna and Navitus that addresses the benefits of those plan.

For members who are enrolled in original Medicare Parts A & B:

- Part A generally covers hospital care,
- Part B generally covers physician services

Important Note:

The Plan will not provide any benefits an Employee, Retiree or Dependent is, or could have been, eligible to receive from Medicare Parts A, B, or C whether or not that person has enrolled in Part A, Part B, or Part C of Medicare, regardless of age, **if Medicare would be primary to this plan**. This means individuals who are eligible for Medicare due to age or disability or End Stage Renal Disease*. Consequently, to avoid a drastic reduction in health benefits, it is essential that each eligible Retiree or Retiree's Dependent be enrolled in both Part A and Part B of Medicare or Medicare Part C (Medicare Advantage) if Medicare would be primary to this Plan.

* The coordination methodology for members eligible for Medicare due to End Stage Renal Disease is different than for members eligible due to age or disability.

In the case of Retired Medicare-eligible Employees (includes those not actively at work), and their covered Medicare-eligible dependents, the Plan's normal Coordination of Benefits provisions shall not apply; Medicare Parts A & B, or Part C shall be the primary provider of coverage. The Plan will reduce its benefits payable by any amount(s) paid or payable by Medicare/Medicare Advantage. In the event such a Medicare-eligible individual

chooses not to enroll for Medicare coverage (Parts A & B, or C), this Plan's payment will still be based on the amount(s) Medicare would have paid had the individual elected coverage under both Parts A & B, or C of Medicare.

In the event that a member receives services from a provider who opted out of Medicare Parts A and/or B and/or C, the Plan shall pay no more than it would have paid had the provider accepted Assignment under parts A and B.

Other health coverage updates – contact information

You should contact Aetna if you have any changes to your other coverage.

- **Online:** Log on to your Aetna Navigator® secure member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call the toll-free Member Services number on your ID card.

Right to receive and release needed information

Aetna has the right to release or obtain any information they need for COB purposes. That includes information needed to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something Aetna would have paid under your plan. When that happens, Aetna will pay your plan benefit to the other plan.

Right of recovery

If Aetna pays more than they should have under the COB rules, Aetna may recover the excess from:

- Any person they paid or for whom they paid, or
- Any other plan that is responsible under these COB rules.

Prescription Drug Expense Benefits

If you are covered under the Consortium's Medicare Part D Prescription Drug Plan, there may be slight variations from the plan provisions noted below. Please consult your Evidence of Coverage (EOC) document provided by Navitus MedicareRX for specific information about that plan's benefits and coverage.

The Prescription Drug Expense Benefits portion of the Plan is a separate coverage from the Medical Expense Benefits. However, in addition to the exclusions indicated below, all provisions and limitations of the Plan shall apply to this coverage. The Plan shall not exclude coverage of any drug approved by the FDA for the treatment of certain types of cancer on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the food and drug administration. Provided, however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

- (i) the American Medical Association Drug Evaluations;
- (ii) the American Hospital Formulary Service Drug Information; or
- (iii) the United States Pharmacopeia Drug Information; or recommended by review article or editorial comment in a major peer reviewed professional journal.

Coverage shall not be provided for any experimental or investigational drugs or any drug which the food and drug administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed unless directed to pursuant to an external appeal. Covered expenses paid under this portion of the Plan shall not be a benefit under any other portion or coverage of the Plan.

Co-Payment

The co-payment amount shall be the amount per prescription specified in the Schedule of Benefits which shall not be considered a covered expense. Payment of the co-payment amount per prescription shall be the responsibility of the Covered Person.

Note: Once your aggregate maximum co-payment per individual or family (please refer to the Schedule of Benefits) is met, further co-payments will be waived.

Covered Drugs

Covered Drugs include only the following:

1. Legend drugs,
2. Insulin on prescription.
3. Tretinoin, all dosage forms (e.g., Retin-A). For individuals over age 25, documentation verifying medical necessity must be submitted to Aetna before reimbursement will be made.
4. Compounded medication of which at least one ingredient is a prescription legend drug; subject to Prior Authorization.
5. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.
6. Nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenyl Ketonuria, branched-chain Ketonuria, galactosemia and momocystinuria as administered under the direction of a physician.
7. Syringes and needles for diabetic use.
8. Enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law has issued a written order. Such written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated cause chronic disability, mental

- retardation or death. Specific diseases for which enteral formulas have proven effective shall include, but are not limited to, inherited diseases of amino-acid or organic acid metabolism; Crohns's Disease, gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death.
9. Prescription drugs approved by the federal Food and Drug Administration for use in the diagnosis and treatment of infertility, except that coverage shall not include prescription drugs in connection with in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers, the reversal of sterilization, sex change procedures, cloning or procedures or services that are experimental. Coverage is limited to individuals whose ages range from twenty-one (21) through forty-four (44) years.
 10. Drugs for bone density as approved by the federal Food and Drug Administration (FDA).
 11. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein, or which contain modified protein which are medically necessary, and such coverage for such modified solid food products shall not exceed \$2,500 per person per calendar year.
 12. Drugs or devices for the treatment of erectile dysfunction; subject to a maximum of 6 pills per month.

Please refer to the section titled List of Prescription Drugs Requiring Precertification for additional information.

Exclusions Applicable To Prescription Drug Expense Benefits

In addition to the General Limitations of the Plan, no benefits shall be payable under the Prescription Drug Expense Benefits portion of the Plan for the following:

1. Non-legend drugs;
2. Charges for the administration or injection of any drug.
3. Therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of intended use, unless otherwise covered under this Plan or required by law.
4. Prescriptions if benefits are provided under any state or federal workers' compensation, employers' liability or occupational disease law;
5. Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual unless directed pursuant to an External Appeal;
6. Immunization agents, unless specifically included, biological sera, blood or blood plasma;
7. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
8. Any prescription refilled in excess of the number specified by the Physician or allowed by the Plan, or any refill dispensed after one year from the Physician's original order;
9. Drugs that are available without a prescription, unless otherwise specifically included;
10. For Medicare primary eligible members only: Drugs that are covered under Medicare Part B must first be processed by Medicare. Secondary claims may then be submitted to Aetna under the medical portion of the plan.

Please refer to the section titled List of Prescription Drugs Requiring Precertification for additional information.

Dispensing Limitations

The amount normally prescribed by Physician, but not to exceed a 30-day supply, except when a maintenance drug is ordered from the Plan's mail order pharmacy vendor. Maintenance medications dispensed through the mail order vendor are limited to a maximum of a 90-day supply.

Non-Participating (Pharmacy) Providers

There is no out-of-network pharmacy coverage. If you obtain covered prescription drugs from a pharmacy which does not participate in the Plan's Prescription Drug Expense Benefits program through Navitus, claims will not be covered.

Retail Network (Up To 31-Day Supply):

The Navitus retail pharmacy network includes local brick-and-mortars, such as Yorktown Pharmacy, in addition to such large retailers as Walgreens, Rite Aid, Shoprite and CVS. You can obtain up to a 31-day supply at retail pharmacies.

You can request that your new pharmacy work with your previous pharmacy to have your prescription refills transferred, if necessary.

90-Day Retail Network:

Navitus has designed an exclusive 90-day retail network that provides additional discounts to the plan and membership. This new 90-day retail network **will not include CVS Pharmacy**, but includes such pharmacies as Walgreens, Rite Aid, ShopRite, and Stop & Shop. For a complete list for your area, please see the pharmacy listing available on Navitus' member portal at www.navitus.com or call Navitus' Customer Care team at 866-333-2757 for assistance in selecting a low-cost pharmacy.

Mail Order Pharmacy

The Consortium utilizes NoviXus to administer a Home Delivery Prescription Drug Program for maintenance or long term use drugs. The mail order program is completely optional. NoviXus Home Delivery mail order kits can be obtained from your School District business or personnel office.

Prescription Drug Coordination of Benefits

If the Consortium's Plan is not the primary payer, the claim may still be adjudicated at the pharmacy. Show your primary prescription drug card and your Navitus card to the pharmacy and ask that both primary and secondary claims be processed. If the pharmacy does not process your secondary claim, you may submit a secondary claim, including itemized receipt and evidence of the primary payers explanation of benefits to Navitus.

Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999

Certification for Certain Prescription Drugs

Certification of the necessity of certain prescription drugs is required before the drug may be dispensed by a pharmacy.

Certification Procedures

It is your responsibility to arrange for the prescriber of the drug to call Navitus at **1-866-333-2757** to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of

laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug.

Navitus will notify you and your healthcare provider of the decision, in writing, within three (3) business days of receipt of the necessary information. If the certification request is denied, this notice will provide the procedure to follow if you choose to appeal the decision.

If the drug is to be dispensed after the certification period ends, certification must again be requested, as described above.

Examples of Prescription Drugs Requiring Certification*

The following **prescription drugs** require certification before the drug is dispensed:

- Appetite suppressants/ weight loss medications
- Specialty drugs (e.g. growth hormones, Multiple Sclerosis agents, Hepatitis C agents, Rheumatoid Arthritis agents)
- Retin-A (over age 25)
- Non-formulary drugs

*Please contact Navitus Customer Service at 1-866-333-2757 for the complete list.

Cost Sharing - Generic Limit

PNW Health Benefits Consortium encourages employees to use the lowest-cost option available. This typically means choosing a generic drug over a brand drug. A generic drug is the same as a brand-name drug in dosage, safety and strength. Generics are taken and work the same way in the body as brands. Quality, performance and intended use are also the same for generics and their brand-name counterparts. The Food and Drug Administration reviews all generic drugs and uses the same strict criteria used for approval of brand-name medications.

- The PNW formulary is a list of preferred drugs covered by our plan. It indicates the tiers at which specific drugs will be covered. In order to provide more affordable options, we have worked with our pharmacy benefit partner, Navitus, to place lower cost generics on preferred tiers that deliver savings to you and the Plan.

If the prescription is marked “Dispensed as Written” (DAW) or if you or your physician specify that a brand name drug must be used when there is a preferred generic available, there will be an additional cost. You will pay the appropriate brand copay plus the difference in cost between the brand and generic drugs. This additional cost can be overridden with an approved authorization. These amounts do not count toward your annual out-of-pocket limit.

Please contact Navitus Customer Care at 1-866-333-2757 for more information on how your prescriber can initiate the authorization process. They are available 24/7, except on Thanksgiving and Christmas.

Compound Medications

Certain ingredients commonly used in prescription compounds will be excluded from coverage. This means the member will be responsible for some or all costs related to compound prescriptions.

A compound medication is one that is made by combining, mixing or altering ingredients to create a customized medication that is not otherwise commercially available. Compounds can contain substances that have not been rigorously tested for safety or effectiveness. Additionally, not all compounds are approved by the FDA.

Preferred drugs are identified on the plan's FORMULARY. The FORMULARY is a listing of drugs which identifies the applicable co-payments. You may obtain a copy of the FORMULARY by calling Navitus customer service number on your identification card or access it on their web site.

The Consortium utilizes a network of more than 50,000 preferred pharmacies administered by Navitus. Prescription purchases at pharmacies within the network are subject to the co-payment. Reimbursements for prescription purchases at non-participating pharmacies are limited to the amount that the Consortium would have been responsible for had a participating pharmacy been used.

The Consortium utilizes NoviXus to administer a home delivery prescription drug program for maintenance, or long-term use drugs. Special provisions exist for the use of the Mail Order Pharmacy.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued.
- You voluntarily stop your coverage.
- The group contract ends.
- You are no longer eligible for coverage.
- Your employment ends.
- You do not make any required contributions.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage.
- You do not make the required contribution toward the cost of dependents' coverage.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Death of Enrollee - Survivor Coverage options below* for more information.

Death of Enrollee - Survivor Coverage

A. In the event of the death of an employee or retiree enrolled for Individual coverage, coverage will terminate on the date of death.

B. In the event of the death of an employee or retiree enrolled for Family coverage, the coverage of any surviving dependents may be continued in accordance with the Federal COBRA continuation coverage rules. The employer shall make a contribution toward the cost of this coverage, for a period of at least 3 months, at the same percentage the employer had been making immediately preceding the death of the employee. After 3 months, the full cost of coverage shall be paid by the surviving spouse or dependents, unless the participating employer establishes administratively or through contract negotiations, a contribution less than 100% for surviving spouses and/or dependents.

1. If the deceased employee or retiree was enrolled for Family coverage and had completed ten (10) years of active service or as an employee having had completed the years of service required to become eligible for vesting in the Teachers' Retirement System or Employees' Retirement System prior to death, then the spouse of the deceased employee may continue coverage as long as the spouse remains unmarried and dependent children may continue coverage for as long as the children would have been eligible had the enrollee lived. The surviving spouse and/or dependents shall pay the full cost of coverage (i.e. the employer's and employee's share). A participating employer may choose to reduce the above ten (10) year requirement. In addition, a participating employer may share in the cost of the surviving spouse's and/or dependent's coverage.
2. Regardless of the length of service, if the death of an active employee enrolled for Family coverage results from a work incurred injury, the surviving dependents may be eligible to continue coverage as dependent survivors. To be eligible, the survivors must be entitled to accidental death benefits payable by a retirement system or pension plan administered by the state or civil division thereof, or to death

benefits provided under the Worker's Compensation law. The surviving spouse and/or dependents shall pay the full cost of coverage (i.e. the employer's and employee's share).

C. To enroll as a surviving dependent or spouse, the spouse or dependent must inform the business or personnel office of the applicable employer within 90 days of the employee's death. No application made after the 90 day period will be accepted. Since application must be made while coverage is still in effect, the dependent survivor(s) will retain the enrollee's original effective date of coverage.

D. The survivor(s) will be issued new identification cards containing the name of the surviving spouse. If there is no spouse and only dependent children are being enrolled, the name of the oldest child will be entered on the card.

E. When the dependent survivors are required to pay the full cost of coverage and only one or two survivors are eligible to continue health benefits, one or two Individual enrollments can be established rather than a Family enrollment. If there are three or more survivors and a Family enrollment is established, a change to two Individual enrollments can be subsequently established at any time if only two of these survivors continue to be eligible.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Contact Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

A. Qualifying Events

Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under the plan in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.
2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
 - Voluntary or involuntary termination of the Subscriber's employment;
 - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
 - Divorce or legal separation from the Subscriber; or
 - Death of the Subscriber.
3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
 - Voluntary or involuntary termination of the Subscriber's employment;
 - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
 - Loss of covered Child status under the plan rules; or
 - Death of the Subscriber.

If You want to continue coverage, You must request continuation from your employer in writing and make the first fee payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

Your employer may charge up to 102% of the total plan costs for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date 36 months after the Subscriber's coverage would have terminated because of termination of employment;
2. If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which fee payments are paid if You fail to make a timely payment; or

6. The date the plan terminates. However, if the plan is replaced with similar coverage, You have the right to become covered under the new plan for the balance of the period remaining for Your continued coverage.

B. Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your employer does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than four (4) years of active duty.

When Your employer does not voluntarily maintain Your coverage during active duty, coverage under the plan will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay your employer the required fee payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under the plan may be resumed as long as You are reemployed or restored to participation in the Plan upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in the Plan upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to your employer for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

C. Availability of Age 29 Dependent Coverage Extension – Young Adult Option

The Subscriber's Child may be eligible to purchase continuation coverage under the plan through the age of 29 if he or she:

1. Is under the age of 30;
2. Is not married;
3. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
4. Lives, works or resides in New York State or The Plan's Service Area; and
5. Is not covered by Medicare.

The Child may purchase continuation coverage even if he or she is not financially dependent on his or her parent(s) and does not need to live with his or her parent(s).

The Subscriber's Child may elect this coverage:

1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be

- prospective and start on the beginning of following month in which the employee submits a completed enrollment application to the Employer's HR Department; or
3. During an annual 30-day open enrollment period, in which case coverage will be prospective and follow Employer's open enrollment guidelines.

The Subscriber or Subscriber's Child must pay the fee that applies to individual coverage. Coverage will be the same as the coverage provided under the plan. The Child's children are not eligible for coverage under this option.

General provisions – other things you should know

Administrative information

The Plan is not responsible for what is done by your **providers**. Even **network providers** are not Aetna's employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group health plan. This document may have amendments too. Under certain circumstances, The Plan or the law may change your plan. Only **the PNW Health Benefits Consortium** may waive a requirement of your plan. No other person can do this.

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

The Plan will try hard to get you access to the services you need even if these things happen.

Legal action

You must complete the internal appeal process before you take any legal action against Aetna or the Plan for any expense or bill. See the *When you disagree -claim decisions and appeal procedures* section. You cannot take any action until 60 days after Aetna receives written submission of claim.

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

Physical examinations and evaluations

At the plan's expense, the plan has the right to have a **physician** of the Plan's choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

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

Intentional deception

If Aetna learns that you defrauded the Plan or you intentionally misrepresented material facts, they can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts Aetna already paid.

Aetna also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If claims were paid for your past coverage, Aetna will want the money back.

You have special rights if we rescind your coverage.

- Aetna will give you 30 days advanced written notice of any rescission of coverage.
- You have the right to an appeal.
- You have the right to a third party review conducted by an independent external review organization.

Financial information

Assignment of benefits

When you see a **network provider** they will usually bill Aetna directly. When you see an **out-of-network provider**, Aetna may choose to pay you or to pay the **provider** directly. Unless Aetna has agreed to do so in writing and to the extent allowed by law, they will not accept an assignment to an **out-of-network provider** or facility under this plan. This may include:

- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this plan.

Financial sanctions exclusions

If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, the Plan cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Recovery of overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator -- Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

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

SUBROGATION AND RIGHT OF RECOVERY

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

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

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

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

Reimbursement

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

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

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

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

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

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

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

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

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

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

Interpretation

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

Jurisdiction

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

Glossary

Administrator (Plan)

Joint Governance Board
Putnam/Northern Westchester Health Benefits Consortium
200 BOCES Drive
Yorktown Heights, NY 10598

Aetna

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

Allowable Charges

The Plan may limit the amount of a provider's charges that will be considered for reimbursement or payment. Charges may be limited to amounts contracted by the Plan or its claims administrator or to amounts that do not exceed Usual, Reasonable or Customary charges. Please refer to the definition of Usual, Reasonable or Customary charges.

Ambulance

A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Ambulatory Care Center

Any public or private establishment with:

- a. an organized medical staff of Physicians;
- b. permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- c. continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
- d. which does not provide services or other accommodations for patients to stay overnight.

Behavioral health provider

An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance abuse**, under the laws of the jurisdiction where the individual practices.

Body mass index

This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

Brand-name prescription drug

A U.S. Food and Drug Administration (FDA) approved **prescription drug** marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Calendar Year

A period of one year beginning with January 1 and ending December 31.

Copay/Copayments

The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.

Cosmetic

Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits

Eligible health services that meet the requirements for coverage under the terms of this plan, including:

1. They are **medically necessary**.
2. You received **precertification** if required.

Covered Person

An individual enrolled and eligible for benefits under this Plan.

Custodial care

Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be **custodial care** even if it prescribed by a **physician** or given by trained medical personnel.

Deductible

The amount you pay for **eligible health services** per Calendar Year before your plan starts to pay as listed in the schedule of benefits.

Dependent

- a. The covered spouse of an Employee;
- b. The term "children" shall include: natural children, legally adopted children, and step-children under age 26. The term "children" may also include any other children under age 26 if the Employee provides support and maintenance and claims them as dependents in accordance with section 152 of the Internal Revenue Code. Proof of dependency may be required.
- c. A child may be a covered dependent child over age 26 if s/he is unmarried, incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law, or physical handicap, chiefly dependent upon the employee for support and maintenance and claimed as a dependent in accordance with section 152(f) of the Internal Revenue Code, and who became so incapable prior to age 26. Proof of such incapacity and dependency must be furnished to the Plan at least 31 days prior to the child's 26th birthday. If a dependent child is 26 or older at the time of initial enrollment, and that child was incapable of self-sustaining enrollment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law, or physical handicap before age 26, such proof as required by the Plan must be submitted within 31 days of the initial effective date of coverage. The Administrator may require, at reasonable intervals, subsequent proof of the child's disability and dependency.

Excluded as a Dependent under a., b. and c. above is:

1. a spouse divorced from the Employee;
2. a Domestic Partner;
3. any person(s) while on active duty in any military service of any country.

Detoxification

The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

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

This can be done by metabolic or other means determined by a **physician** or a nurse practitioner working within the scope of their license. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Directory

The list of **network providers** for your plan. The most up-to-date directory for your plan appears at www.aetna.com under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for **providers** that participate in your specific plan. **Network providers** may only be considered for certain plans.

Disability/Period of Disability

Any period of illness or injury, or multiple illnesses or injuries arising from the same cause, including any and all complications therefrom, which are not separated by complete recovery as certified by the attending Physician and return to active full-time employment in the case of the Employee; or in the case of a Dependent, return to the resumption of the normal activities of a person of the same age and sex in good health. For the purpose of renewing in-patient hospital and/or convalescent nursing home/extended care facility/skilled nursing facility benefits, a new period of disability shall begin when the Covered Person has not been confined in such a facility for at least 90 days.

Durable medical equipment (DME)

Equipment and the accessories needed to operate it, that is:

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

Effective date of coverage

The date your and your dependent's coverage begins under this Plan as determined by your Employer.

Eligible health services

The health care services and supplies listed in the *Eligible health services under your plan* section and not carved out or limited in the *exclusions* section or in the schedule of benefits.

Emergency admission

An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services**.

Emergency medical condition

A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of a severe nature. And that if you don't get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus

Emergency services

Treatment given in a **hospital's** emergency room for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize an **emergency medical condition**.

Employer/Participating Employer

The Employer is, individually or collectively, the various school districts and BOCES which elect to become Participating Employers in the Putnam/Northern Westchester Health Benefits Consortium.

Experimental or investigational

A drug, device, procedure, or treatment that is found to be **experimental or investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness or injury** involved
- The needed approval by the FDA has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.

External Appeal Agent

An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Formulary

A formulary is a listing of prescription medications identifying applicable co-payments for preferred and non-preferred drugs. Preferred drugs are selected based upon approval of the Federal Food and Drug Administration (FDA) and cost effectiveness. Non-preferred drugs must also be approved by the FDA but are more costly. The co-payment is highest for non-preferred drugs.

Gender Pronouns

Whenever the masculine pronoun is used in this document it shall include the feminine gender unless the context clearly indicates otherwise.

Grievance

A complaint that You communicate to Aetna that does not involve a utilization review determination.

Generic prescription drug

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand

name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, nurses, and physical therapists.

Home health care agency

An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan

A plan of services prescribed by a **physician** or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a **hospital** or if you are homebound.

Hospice care

Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and quality of life, rather than cure.

Hospice care agency

An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.

Hospice care program

A program prescribed by a **physician** or other **health professional** to provide **hospice care** and supportive care to their families.

Hospice facility

An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital

An institution licensed as a **hospital** by applicable state and federal laws, and accredited as a **hospital** by The Joint Commission (TJC).

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- Psychiatric hospital
- Residential treatment facility for substance abuse
- Residential treatment facility for mental disorders
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

Illness

Poor health resulting from disease of the body or mind.

Infertile/infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
 - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
 - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
 - At least 12 cycles of donor insemination if under the age of 35
 - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
 - At least 2 abnormal semen analyses obtained at least 2 weeks apart

Injury

Physical damage done to a person or part of their body.

Institutes of Excellence™ (IOE) facility

A facility designated by **Aetna** in the **provider directory** as Institutes of Excellence **network provider** for specific services or procedures.

Intensive Outpatient Program (IOP)

Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of **medically necessary** services delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint,
- A myofascial pain dysfunction (MPD) of the jaw, or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy

A pharmacy where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit

The maximum out-of-pocket amount for payment of **copayments** and payment percentage including any **deductible**, to be paid by you or any covered dependents per Calendar Year for **eligible health services**.

Medically necessary/Medical necessity

Health care services that a **provider** exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury** or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in agreement issues involving clinical judgment.

Medicare

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended by the Social Security Amendment of 1965 or as later amended.

Mental disorder

A **mental disorder** as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. **Mental disorders** are usually associated with significant distress or disability in social, occupational, or other important activities.

Morbid obesity/morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes

Negotiated charge

For health coverage, this is either:

The amount a **network provider** has agreed to accept for providing services, **prescription drugs** or supplies to plan members. This does not include **prescription drug** services from a **network pharmacy**.

Network provider

A **provider** listed in the **directory** for your plan. However, a National Advantage Program (NAP) provider listed in the NAP directory is not a **network provider**.

Non-Participating Provider

A Provider who is not a Network Provider or National Advantage Program (NAP) Provider and does not appear in the Directory for Your plan.

Out-of-network pharmacy

A **pharmacy** that is not a **network pharmacy** or a National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan.

Out-of-network provider

A **provider** who is not a **network provider**.

Partial hospitalization treatment

Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental disorder** or **substance abuse** issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

Participating Provider

A Provider listed in the Directory for Your plan. However, a NAP Provider listed in the NAP directory is not a Participating Provider.

Payment Percentage

The specific percentage the plan to pays for a health care service listed in the schedule of benefits.

Pharmacy

An establishment where **prescription** drugs are legally dispensed. This includes a **retail pharmacy**, **mail order pharmacy** and **specialty pharmacy**.

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

To the extent performing services covered by the Plan, a person acting within the scope of his license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Chiropractic (D.C.) and Doctor of Optometry (O.D.). The term Physician shall also be extended to include a Doctor of Psychology (Ph.D.), Registered Physical Therapist (R.P.T.), Licensed Speech Language Pathologist and Audiologist, Registered Nurse Practitioner (R.N. Practitioner) and Registered Occupational Therapist (O.R.T.). The term Physician shall also include a social worker who is certified pursuant to article one hundred fifty-four of the New York State Education Law; and who, in addition, has either six or more years of post-degree experience in psychotherapy, satisfactory to the (New York) state board for social work, or six or more years of post-degree experience in psychotherapy under the supervision, satisfactory to the (New York) state board for social work, of a psychiatrist, a certified and registered psychologist or another social worker who is qualified as a social worker as defined above, or has a combination of the (New York) state required experience specified above which totals an aggregate of six or more years, satisfactory to the (New York) state board for social work; and who in addition is listed by the (New York) state board for social work as qualified for reimbursement. A qualified social worker shall also include a certified social worker providing services outside the State of New York, provided such social worker is, by the resident state statutes, qualified to provide such services, and required by the resident state statutes to be covered under a group health plan or service.

Plan Name

The name of the Plan is the PUTNAM/NORTHERN WESTCHESTER HEALTH BENEFITS CONSORTIUM COOPERATIVE HEALTH BENEFITS PLAN.

The Plan currently utilizes AETNA for medical/hospital claims administration and Navitus Health Solutions as prescription drug claims administrator.

Aetna's Medicare Advantage PPO and Navitus' Medicare Part D drug program are provided for most Medicare eligible members.

Precertification, precertify

A requirement that you or your **physician** contact **Aetna** before you receive coverage for certain services. This may include a determination by Aetna as to whether the service is **medically necessary** and eligible for coverage.

Preferred Provider

A Provider who has a contract with Aetna to provide services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see a Preferred Provider.

Prescriber

Any **provider** acting within the scope of his or her license, who has the legal authority to write an order for outpatient **prescription drugs**.

Prescription

A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

Prescription drug

An FDA approved drug or biological which can only be dispensed by **prescription**.

Primary care physician (PCP)

A **physician** who:

- The **directory** lists as a **PCP**
- Is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist, a pediatrician, OB, GYN or OB/GYN
- Is shown on **Aetna's** records as your **PCP**

Provider(s)

A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric hospital

An institution specifically licensed or certified as a **psychiatric hospital** by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, **mental disorders** (including substance-related disorders) or mental illnesses.

Psychiatrist

A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	Recognized charge
Professional services and other services or supplies not mentioned below	The reasonable amount rate
Services of hospitals and other facilities	The reasonable amount rate
Prescription drugs	
Important note: If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.	

Recognized charge does not apply to involuntary services.

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider**. NAP **providers** are **out-of-network providers** and third party vendors that have contracts with Aetna but are not **network providers**. Except for involuntary services, when you get care from a NAP **provider** your out-of-network cost sharing applies.

Special terms used

- Facility charge review (FCR) rate is an amount that Aetna determines is enough to cover the facility **provider's** estimated costs for the service and leave the facility **provider** with a reasonable profit. For **hospitals** and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. Aetna may adjust the formula as needed to maintain the reasonableness of the recognized charge. For example, Aetna may make an adjustment if they determine that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If Aetna determines they need more data for a particular service or supply, they may base rates on a wider geographic area such as an entire state.
- Involuntary services are services or supplies that are one of the following:
 - Performed at a network facility by an **out-of-network provider**, unless that **out-of-network provider** is an assistant surgeon for your **surgery**
 - Not available from a **network provider**
 - **Emergency services**

Aetna will calculate your cost share for involuntary services in the same way as they would if you received the services from a **network provider**.

- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. Aetna updates their systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, Aetna uses one or more of the items below to determine the rate:
 - The method CMS uses to set Medicare rates
 - What other **providers** charge or accept as payment
 - How much work it takes to perform a service
 - Other things as needed to decide what rate is reasonable for a particular service or supply

Aetna may make the following exceptions:

- For inpatient services, their rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
 - Aetna’s rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
 - For anesthesia, Aetna’s rate is 105% of the rates CMS establishes for those services or supplies.
 - For laboratory, Aetna’s rate is 75% of the rates CMS establishes for those services or supplies.
 - For **DME**, Aetna’s rate is 75% of the rates CMS establishes for those services or supplies.
 - For medications payable/covered as medical benefits rather than **prescription drug** benefits, Aetna’s rate is 100% of the rates CMS establishes for those medications.
- “Reasonable amount rate” means your plan has established a reasonable rate amount as follows:

Service or supply	Reasonable amount rate
Professional services	80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically: <ul style="list-style-type: none"> • Aetna updates their systems with these changes within 180 days after receiving them from FAIR Health • If the FAIR Health database becomes unavailable, Aetna has the right to substitute a different database that they believe is comparable If the alternative data source does not contain a value for a particular service or supply, Aetna will base the recognized charge on the Medicare allowed rate.
Inpatient and outpatient charges of hospitals	The Facility charge rate (FCR) rate
Inpatient and outpatient charges of facilities other than hospitals	The Facility charge rate (FCR) rate

Aetna’s reimbursement policies

The Plan reserve the right to apply Aetna’s reimbursement policies to all out-of-network services including involuntary services. Aetna’s reimbursement policies may affect the **recognized charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Aetna’s reimbursement policies are based on their review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in the relevant clinical areas

Aetna uses commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits

Aetna has online tools to help decide whether to get care and if so, where. Use the “Estimate the Cost of Care” tool on Aetna Navigator®. **Aetna’s** secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools.

R.N.

A registered nurse.

Residential treatment facility (mental disorders)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Aetna** or is accredited by one of the following agencies, commissions or committees for the services being provided:
 - The Joint Commission (TJC)
 - The Committee on Accreditation of Rehabilitation Facilities (CARF)
 - The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
 - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for residential treatment programs treating **mental disorders**:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week.
- The patient must be treated by a **psychiatrist** at least once per week.
- The medical director must be a **psychiatrist**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

Residential treatment facility (substance abuse)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for **substance abuse** residential treatment programs. And is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:
 - The Joint Commission (TJC)
 - The Committee on Accreditation of Rehabilitation Facilities (CARF)
 - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
 - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for chemical dependence residential treatment programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming.
- The medical director must be a **physician**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

In addition to the above requirements, for chemical dependence **detoxification** programs within a residential setting:

- An **R.N.** must be onsite 24 hours per day for 7 days a week within a residential setting.
- Residential care must be provided under the direct supervision of a **physician**.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Schedule of Benefits

The section of this Booklet that describes the Copayments, Deductibles, Payment Percentage, Out-of-Pocket Limits, Preauthorization requirements, Referral requirements, and other limits on Covered Services.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation **hospitals**, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental disorders** or **substance abuse**.

Skilled nursing services

Services provided by an **R.N.** or **L.P.N.** within the scope of their license.

Specialist

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

Stay

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

Substance abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental disorder** that are a focus of attention or treatment, or an addiction to nicotine products, food or caffeine intoxication.

Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery or surgical procedures

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Telemedicine

A telephone or internet-based consult with a Provider that has contracted with Aetna to offer these services.

Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

Urgent Care

Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

Urgent condition

An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Usual, Reasonable and Customary Charges (URC)

The normal and necessary charges made for similar services by the providers of medical services who are practicing in the same geographic area or the actual charge, whichever is less. Determination of whether or not a charge is URC shall be made by the Claims Administrator based on nationally obtained and recognized survey data or on data received from an insurance company which, as a major portion of its business, is involved in the adjudication of health care claims. URC shall also mean, and is interchangeable with, Reasonable charge, Recognized charge, Customary charge, Usual Customary and Reasonable (UCR) charges, and references of a similar nature used to describe Covered Expenses, charges or allowable amounts.

Waiting Period

That period of time between the Employee's date of eligibility and/or hire and the date the Employee becomes covered under this Plan.

The Waiting Period for Employees of each respective Participating Employer shall be determined by the Participating Employer.

Walk-in clinic

A free-standing health care facility. Neither of the following should be considered a **walk-in clinic**:

- An emergency room
- The outpatient department of a **hospital**

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/home/regsguidance.asp>, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

Notice of Privacy Practices

Notice of Putnam/Northern Westchester Health Benefits Consortium Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The effective date of this Notice of the Putnam/Northern Westchester Health Benefits Consortium Health Information Privacy Practices (the "Notice") is 2019.

The Putnam/Northern Westchester Health Benefits Consortium (the "Plan") provides health benefits to eligible employees of The Putnam/Northern Westchester Health Benefits Consortium (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, retirees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and retirees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, retiree or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

Receipt of Your PHI by the Company and Business Associates

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates, and any of their subcontractors without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

How the Plan May Use or Disclose Your PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others. The Plan can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation. The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights With Respect to Your PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information

for the treatment, payment and health care operations purposes explained in this Notice.

Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in

writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice.

Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
Email to: OCRCompliant@hhs.gov

Contact Information

For more information on the Plan's privacy policies or your rights under HIPAA, contact:

Privacy Officer
Putnam/Northern Westchester
Health Benefit Consortium
200 Boces Drive
Yorktown Heights, NY 10598
(914) 248-3694

General Information

NAME AND TYPE OF ADMINISTRATION OF THE PLAN

The Putnam/Northern Westchester Health Benefits Consortium administers a health plan to reimburse non-occupational illness and injury claims through contract administration by third-party claims administrators.

NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR THE SERVICE OF LEGAL PROCESS

Director of Health and Welfare Benefits
Putnam/Northern Westchester Health Benefits Consortium
200 BOCES Drive
Yorktown Heights, NY 10598

NAME AND ADDRESS OF THE PLAN ADMINISTRATOR

Joint Governance Board
Putnam/Northern Westchester Health Benefits Consortium
200 BOCES Drive
Yorktown Heights, NY 10598

NAME AND ADDRESS OF THE MEDICAL CLAIMS ADMINISTRATOR

AETNA
P. O. Box 981106
El Paso, TX 79998-1106

NAME AND ADDRESS OF THE PRESCRIPTION DRUG CLAIMS ADMINISTRATOR

Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999

DESCRIPTION OF RELEVANT PROVISIONS OF ANY APPLICABLE COLLECTIVE BARGAINING AGREEMENT

The current applicable collective bargaining agreements are between the various participating School Districts and their collective bargaining units and/or unions representing Employees eligible to participate in the Plan. An Employee may obtain a copy of any such bargaining agreement applicable to him from his Employer.

DATES OF THE PLAN YEAR

July 1st through the following June 30th

INTERNAL REVENUE SERVICE TAX IDENTIFICATION NUMBER

Tax Identification Number 13-3962250

CMS HEALTH INSURANCE OVERSIGHT SYSTEM HEALTH PLAN IDENTIFICATION NUMBER

HPID 7679576422

PLAN AMENDMENT/TERMINATION PROCEDURE

The Joint Governance Board, by a majority decision and as authorized by the Trustees under separate agreement, may alter, change or amend any Plan coverage or benefit if such change, modification or amendment is determined to be required for the prudent administration of the Plan. Any decisions of the Joint Governance Board shall be binding upon all members of the Plan. This includes, but is not limited to, active employees, retirees, dependents of employees and retirees, and beneficiaries of Continued Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.