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HEALTH BENEFITS RESOURCE GUIDE

WHERE TO CALL

Benefit Fund
Member Services Department
(646) 473-9200
For answers to questions about your eligibility or prescription drug benefits.

Aetna
Member Services Department
(866) 658-2455
For answers to questions about your medical benefits.

Cigna
Member Services Department
(800) 244-6224 (CIGNA24)
For answers to questions about your dental benefits.

For the Aetna
24-Hour Health Line
(800) 556-1555

You can also visit the Fund’s website at www.1199SEIUBenefits.org for forms, directories and other information.

BENEFIT BRIEF

- Benefits provided by Aetna
- Each individual should select an Aetna Primary Care Physician
- Other than for emergencies, services must be performed by Aetna Participating Providers
- Referrals to specialists not required

- Individual and family deductibles will apply for some procedures
- Co-payments and limitations may apply for some procedures
- $50,000 annual maximum, increasing to $75,000 per member effective January 1, 2012

Full-Time Eligibility Class I: Family Coverage for Member, Spouse and Dependent Children

Part-Time Eligibility Classes II and III: Coverage for Member Only

Note: Genesis employees and their eligible dependents are eligible for medical benefits based upon your family election.
SECTION II. A
BENEFITS PROVIDED BY AETNA

1. HOW YOUR MEDICAL PLAN WORKS

ACCESSING NETWORK PROVIDERS AND BENEFITS

The Primary Care Physician

To access benefits, you should select a Primary Care Physician (PCP) from Aetna’s network of providers. Each covered family member may select his or her own PCP. If your covered dependent is a minor, or otherwise incapable of selecting a PCP, you should select a PCP on their behalf.

You may search online for the most current list of participating providers in your area by using DocFind, Aetna’s online provider directory, at www.aetna.com. You can choose a PCP based on geographic location, group practice, medical specialty, language spoken or hospital affiliation. You may also request a printed copy of the provider directory by calling the toll-free number on your Aetna ID card.

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

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

Changing Your PCP

You may change your PCP at any time on Aetna’s website, www.aetna.com, or by calling the Aetna Member Services toll-free number on your identification card. The change will become effective upon Aetna’s receipt and approval of the request.

Specialists and Other Network Providers

- You may directly access specialists and other healthcare professionals in the network for covered services and supplies under this Booklet.

COST SHARING – YOU SHARE IN THE COST OF YOUR BENEFITS

- For certain types of services and supplies, you will be responsible for any payment percentage or copayments after you have satisfied the individual or family deductible.

- The Plan will pay for covered expenses up to its maximum. Other than any payment percentage or copayment, you will not have to pay any balance bills above the negotiated charge for that covered service or supply as long as you use an Aetna participating provider.
• You may be billed for any deductible or any non-covered expenses that you incur.

UNDERSTANDING PRECERTIFICATION

Precertification

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

As part of precertification, you may be required to get a second or third opinion through an independent medical exam. If the plan requires you to obtain a second or third opinion, the plan will fully cover the second or third opinion with no deductible.

The Precertification Process

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

Your Provider must notify Aetna to precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require precertification pursuant to this Booklet in accordance with the following timelines:

To obtain precertification, call Aetna at the telephone number listed on your ID card.

SERVICES AND SUPPLIES THAT REQUIRE PRECERTIFICATION

Inpatient and Outpatient Care

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

EMERGENCY AND URGENT CARE

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

• An emergency medical condition;
or
• An urgent condition.
In Case of a Medical Emergency

An emergency medical condition is a recent and severe condition, sickness, or injury, including (but not limited to) severe pain, which would lead a prudent layperson (including the parent or guardian of a minor child or the guardian of a disabled individual) possessing an average knowledge of medicine and health, to believe that failure to get immediate medical care could result in:

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

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

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your primary care physician, provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your PCP to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition (one that does not meet the criteria above), the plan will not cover the expenses you incur.

Coverage for Emergency Medical Conditions

The plan will pay for hospital services provided in an emergency room to evaluate and treat an emergency medical condition.

Please contact your PCP after receiving treatment of an emergency medical condition.

Important Reminder

If you visit a hospital emergency room for a non-emergency condition, the plan will not cover your expenses. No other plan benefits will pay for non-emergency care in the emergency room.

In Case of an Urgent Condition

An urgent condition is a sudden illness, injury or condition that:

- Requires prompt medical attention to avoid serious deterioration of your health;
- Cannot be adequately managed without urgent care or treatment;
- Does not require the level of care provided in a hospital emergency room; and
Requires immediate outpatient medical care that cannot wait for your physician to become available. Call your PCP if you think you need urgent care. Network providers are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any physician or urgent care provider, in- or out-of-network, for an urgent care condition if you cannot reach your physician.

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

Coverage for an Urgent Condition
The plan will pay for the services of an urgent care provider to evaluate and treat an urgent condition.

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

To keep your out-of-pocket costs lower, your follow-up care should be accessed through your PCP. If you seek follow-up care from a network provider who is not your PCP, you will need to secure a referral from your PCP to minimize your out-of-pocket expenses.

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

2. REQUIREMENTS FOR COVERAGE
To be covered by the plan, services and supplies must meet all of the following requirements:

a. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
   • Be included as a covered expense in this Booklet;
   • Not be an excluded expense under this Booklet. Refer to the Exclusions sections of this Booklet for a list of services and supplies that are excluded;
   • Not exceed the maximums and limitations outlined in this Booklet; and
   • Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.

b. The service or supply must be provided while coverage is in effect.
c. The service or supply must be medically necessary.

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

3. WHAT THE PLAN COVERS
Many preventive and routine medical expenses as well as expenses incurred for a serious illness or injury are covered. This section describes which expenses are covered expenses. Only expenses incurred for the services and supplies shown in this section are covered expenses. Please see the overview for information on percentage payments, copayments or frequency limitations. Other limitations and exclusions may apply.

a. WELLNESS
This section on Wellness describes the covered expenses for services and supplies provided when you are well.

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

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases; and
- Testing for tuberculosis.

Covered expenses for dependent children:
- An initial hospital checkup and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

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

- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap smear every 12 months;
- 1 gynecological exam every 12 months;
- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.
The following tests are covered expenses if you are age 50 and older when recommended by your physician:

- 1 sigmoidoscopy every 5 years for persons at average risk; or
- 1 double contrast barium enema (DCBE) every 5 years for persons at average risk; or
- 1 colonoscopy every 10 years for persons at average risk for colorectal cancer.

**Family Planning Services**

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

**Contraception Services**

Other than prescriptions for contraceptive drugs and devices covered through the Fund’s prescription drug benefit, covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Consultations;
- Exams;
- Procedures; and
- Other medical services and supplies.

Charges incurred for contraceptive services while confined as an inpatient are not covered.

**Other Family Planning**

Covered expenses include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

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

Please also see the section on pregnancy and infertility-related expenses in this Booklet.

**b. PHYSICIAN SERVICES (VISITS, SURGERY AND ANESTHESIA)**

**Physician Visits**

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

- Immunizations for infectious disease, but not if solely for your employment or travel;
- Allergy testing and allergy injections; and
- Charges made by the physician for supplies, radiological services, X-rays and tests provided by the physician.
Surgery
Covered expenses include charges made by a physician for:
• Performing your surgical procedure;
• Pre-operative and post-operative visits; and
• Consultation with another physician to obtain a second opinion prior to the surgery.

Anesthesia
Covered expenses include charges for the administration of anesthesia and oxygen by a physician, other than the operating physician, or Certified Registered Nurse Anesthetist (CRNA) in connection with a covered procedure.

Important Reminder
Certain procedures need to be pre-certified by Aetna.

ALTERNATIVES TO PHYSICIAN OFFICE VISITS
Walk-In Clinic Visits
Covered expenses include charges made by network walk-in clinics for unscheduled, non-emergency illnesses and injuries, and the administration of certain immunizations administered within the scope of the clinic’s license.

c. HOSPITAL EXPENSES AND ALTERNATIVES
Covered medical expenses include services and supplies provided by a hospital during your stay.

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

Room and board charges also include:
• Services of the hospital’s nursing staff;
• Admission and other fees;
• General and special diets; and
• Sundries and supplies.

Other Hospital Services and Supplies
Covered expenses include charges made by a hospital for services and supplies furnished to you in connection with your stay such as:
• Ambulance services.
• Physicians and surgeons.
• Operating and recovery rooms.
• Intensive or special care facilities.
• Administration of blood and blood products, but not the cost of the blood or blood products.
• Radiation therapy.
• Speech therapy, physical therapy and occupational therapy.
• Oxygen and oxygen therapy.
• Radiological services, laboratory testing and diagnostic services.
• Medications.
• Intravenous (IV) preparations.
• Discharge planning.

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

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

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

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

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

EMERGENCY ROOMS ARE FOR EMERGENCIES
A hospital emergency room should be used only in the case of a legitimate medical Emergency. To be considered an Emergency, your emergency room visit must meet the definition of Emergency (see Section IX) and must occur within 72 hours of an injury or the onset of a sudden and serious illness.

NON-EMERGENCY TREATMENT CAN BE COSTLY TO YOU
If you use the emergency room for non-Emergency treatment, Aetna will not pay any more than it would for non-Emergency treatment in a doctor’s office or clinic, which may result in a large out-of-pocket cost to you.

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

Please contact your PCP after receiving treatment of an urgent condition.

If you visit an urgent care provider for a non-urgent condition, the plan will not cover your expenses.
ALTERNATIVES TO HOSPITAL STAYS

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- An office-based surgical facility of a physician or a dentist;
- A surgery center; or
- The outpatient department of a hospital.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a surgery center or hospital; and
- The surgery is not normally performed in a physician’s or dentist’s office.

Important Note

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

The following outpatient surgery expenses are covered:

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

Limitations

Not covered under this section are charges made for:

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

Birthing Center

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

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

Hospice Care

Covered expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program:
Facility Expenses
The charges made by a hospital, hospice or skilled nursing facility for:

- Room and board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management;
- 210 days per lifetime, and
- Services and supplies furnished to you on an outpatient basis.

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

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

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

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

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

- Daily room and board charges over the semi-private room rate.
- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
• Homemaker or caretaker services. These are services that are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

• Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.

**Important Reminders**

Refer to the Overview for hospice care maximums and member cost-sharing.

Inpatient hospice care and home health care must be precertified by Aetna.

d. **OTHER COVERED HEALTHCARE EXPENSES**

**Ambulance Service**

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

**Ground Ambulance**

Covered expenses include charges for transportation:

• To the first hospital where treatment is given in a medical emergency.

**Air or Water Ambulance**

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

• Ground ambulance transportation is not available; and

• Your condition is unstable, and requires medical supervision and rapid transport; and

• In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the
required services or facilities to treat your condition and you need to be transported to another hospital; and the two conditions above are met.

Limitations

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

- If an ambulance service is not required by your physical condition; or
- If the type of ambulance service provided is not required for your physical condition; or
- By any form of transportation other than a professional ambulance service.

e. DIAGNOSTIC (LAB AND RADIOLOGY) AND PREOPERATIVE TESTING

Diagnostic Complex Imaging Expenses

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

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

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

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services other than diagnostic complex imaging, lab services, and pathology and other tests provided to diagnose an illness or injury. The charges must be made by a physician, hospital or licensed radiological facility or lab.

Important Reminder

Refer to the Overview for details about any deductible, payment percentage and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

Outpatient Preoperative Testing

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

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

- Test results should appear in your medical record kept by the hospital or surgery center where the surgery is performed.

**Limitations**

The plan does not cover diagnostic complex imaging expenses if your tests indicate that surgery should not be performed because of your physical condition. The plan will pay for the tests, however surgery will not be covered.

**f. DURABLE MEDICAL AND SURGICAL EQUIPMENT (DME)**

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

The initial purchase of DME if:

- Long-term care is planned; and

- The equipment cannot be rented or is likely to cost less to purchase than to rent.

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

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and

- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

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

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

**g. EXPERIMENTAL OR INVESTIGATIONAL TREATMENT**

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

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;

- Standard therapies have not been effective or are inappropriate;

- Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;

- You are enrolled in a clinical trial that meets these criteria;
• The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group C/treatment IND status;

• The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;

• The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food and Drug Administration or the Department of Defense) and conforms to the NCI standards;

• The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and

• You are treated in accordance with protocol.

h. PREGNANCY-RELATED EXPENSES

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

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

• 48 hours after a vaginal delivery; and

• 96 hours after a Caesarean section.

• A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, the plan will pay for one post-delivery home visit by a healthcare provider.

Covered expenses for a birthing center are described under Alternatives to Hospital Care.

Note: Covered expenses also include services and supplies provided for circumcision.

Prosthetic Devices

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

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

• Orthopedic shoes, therapeutic shoes, foot orthotics or other devices to support the feet, unless 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; or

• Trusses, corsets, and other support items or

• Any item listed in the Exclusions section.
i. **SHORT-TERM REHABILITATION THERAPY SERVICES**

Covered expenses include charges for short-term therapy services when prescribed by a physician as described below. 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; or
- A physician.

Charges for the following short-term rehabilitation expenses are covered:

**Cardiac and Pulmonary Rehabilitation Benefits**

Cardiac rehabilitation benefits are available as part of an inpatient hospital stay.

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

Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this Booklet.

A “visit” consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

Please see the Overview for a description of limitations, maximums and cost-sharing.

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RECONSTRUCTIVE OR COSMETIC SURGERY AND SUPPLIES

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

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury that occurred when the member was eligible under this plan, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

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

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when:
  - the defect results in severe facial disfigurement, or
• the defect results in significant functional impairment and the surgery is needed to improve function

RECONSTRUCTIVE BREAST SURGERY

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

Important Notice
A benefit maximum may apply to reconstructive or cosmetic surgery services. Please refer to the overview.

SPECIALIZED CARE
Chemotherapy

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

Radiation Therapy Benefits

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

OUTPATIENT INFUSION THERAPY BENEFITS

Covered expenses include charges made on an outpatient basis for infusion therapy by:
• A freestanding facility;
• The outpatient department of a hospital; or
• A physician in his/her office or in your home.

Not included under this infusion therapy benefit are charges incurred for enteral nutrition; blood transfusions and blood products; dialysis; and insulin.

SPINAL MANIPULATION TREATMENT

Covered expenses include charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum of 12 visits per calendar year. This maximum does not apply to expenses incurred:
• During your hospital stay;
• For treatment of scoliosis;
• For fracture care; or
• For surgery. This includes pre- and post-surgical care provided or ordered by the operating physician.

j. TRANSPORT SERVICES
Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue. The network level of benefits is paid only for a treatment received at a facility designated by the plan as an Institute of Excellence (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

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

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

Important Reminders
To ensure coverage, all transplant procedures need to be pre-certified by Aetna.

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

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

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

Important Notice

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

Treatment of Mental Disorders

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

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

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

Inpatient Treatment – 30 days per year

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

Partial Confinement Treatment – 30 days per year

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

Outpatient Treatment – 60 days per year

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

The plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.
Important Reminder
Inpatient care must be pre-certified by Aetna. See the overview for maximums and cost-sharing.

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

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

See the Overview maximums and cost-sharing for the treatment of alcoholism and substance abuse.

Inpatient Treatment for Alcoholism and Substance Abuse – 30 Days per Year
The plan covers room and board at the semi-private room rate and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriately licensed by the State Department of Health or its equivalent.

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

Outpatient Treatment for Alcoholism and Substance Abuse – 60 Days per Year
The plan covers outpatient treatment of alcoholism or substance abuse.

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

Partial Confinement Treatment for Alcoholism and Substance Abuse
Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically directed intensive treatment of alcoholism or substance abuse.

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

**Important Reminder**

Inpatient care must be pre-certified by Aetna. See the Overview for maximums and cost-sharing.

### ORAL AND MAXILLOFACIAL TREATMENT (MOUTH, JAWS AND TEETH)

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

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

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

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

### 1. VISION

Covered expenses include:

- One pair of glasses every 24 months, including contact lenses
- Reimbursement to the member upon receipt of a claim
- $125 allowance once every 24 months

### 4. WHAT’S NOT COVERED

Please also see general exclusions in Section VII.D.

#### a. MEDICAL PLAN EXCLUSIONS

Not every medical service or supply is covered by the plan, even if prescribed, recommended or approved by your physician or dentist. Charges made for the following are not covered:

- Acupuncture, acupressure and acupuncture therapy.
- Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan’s Test), treatment of non-specific candida sensitivity and urine autoinjections.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Any non-emergency charges incurred outside of the United States:

1. If you traveled to such location to obtain supplies, even if otherwise covered under this Booklet, or
2. Such supplies are unavailable or illegal in the United States; or
3. The purchase of such supplies outside the United States is considered illegal.

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

Artificial organs: Any device intended to perform the function of a body organ.

Behavioral Health Services:

- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the What the Plan Covers section of this Booklet.

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

Charges for a service or supply furnished by a network provider in excess of the negotiated charge.

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

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

Educational services:

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

Examinations:

- Any health examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer/employee is required to provide under a labor agreement;
required by any law of a
government, securing insurance
or school admissions, or
professional or other licenses;
required to travel, attend a
school, camp, or sporting event
or participate in a sport or
other recreational activity; and
any special medical reports not
directly related to treatment
except when provided as part
of a covered service.
Experimental or investigational drugs,
devices, treatments or procedures,
except as described in this booklet.
Facility charges for care services or
supplies provided in:
rest homes;
assisted living facilities;
similar institutions serving as an
individual's primary residence or
providing primarily custodial or
rest care;
health resorts;
spas, sanitariums; or
infirmaries at schools, colleges,
or camps.
Food items: Any food item,
including infant formulas, nutritional
supplements, vitamins, including
prescription vitamins, medical foods
and other nutritional items, even if it is
the sole source of nutrition.
Foot care: Except as specifically
covered for diabetics, any services,
supplies, or devices to improve
comfort or appearance of toes, feet or
ankles, including:
Treatment of calluses, bunions,
toenails, hammer-toes,
sublimations, fallen arches,
weak feet, chronic foot pain or
conditions caused by routine
activities such as walking, running,
working or wearing shoes; and
Shoes (including orthopedic
shoes), orthotics, arch supports,
shoe inserts, ankle braces, guards,
protectors, creams, ointments
and other equipment, devices and
supplies, even if required following
a covered treatment of an illness
or injury.
Growth/Height: Any treatment, device,
drug, service or supply to increase
or decrease height or alter the rate of
growth, including surgical procedures,
devices to stimulate growth, and
growth hormones.
Hearing:
Hearing exams given during a stay
in a hospital or other facility; and
Any tests, appliances, and
devices for the improvement of
hearing, including hearing aids
and amplifiers, or to enhance
other forms of communication to
compensate for hearing loss, or
devices that simulate speech.
Home and mobility: Any addition or alternation to a home, workplace or other environment, or vehicle and any related equipment or device, including:

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

Home uterine activity monitoring.

Infertility: any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization
- Infertility services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Ovulation induction and intrauterine insemination services if you are not fertile.

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

Miscellaneous charges for services or supplies including:

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

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

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

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

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

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:
  • Surgical procedures to alter the appearance or function of the body;
  • Hormones and hormone therapy;
  • Prosthetic devices; and
  • Medical or psychological counseling.

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

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

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.
Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

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

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the Continuation of Coverage section of this Booklet.

Services that are not covered under this Booklet.

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

Services and supplies provided by an out-of-network provider.

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

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in this Booklet.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include pervasive developmental disorders (including autism), Down Syndrome, and cerebral palsy, as they are considered both developmental and/or chronic in nature.
Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in this Booklet.

Unauthorized services, including any service obtained by or on behalf of a covered person without precertification by Aetna when required. This exclusion does not apply in a medical emergency or in an urgent care situation.

Vision-related services and supplies. The plan does not cover:

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

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of co-morbid conditions; except as provided by this Booklet, including but not limited to:

• Liposuction, banding, gastric stapling, gastric bypass and other forms of bariatric surgery; surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity;

• Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;

• Counseling, coaching, training, hypnosis or other forms of therapy; and

• Exercise programs, exercise equipment, membership in health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

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

5. GENERAL PROVISIONS

Type of Coverage

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

Physical Examinations

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

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

a. ADDITIONAL PROVISIONS

The following additional provisions apply to your coverage:

- This Booklet applies to coverage only, and does not restrict your ability to receive healthcare services that are not, or might not be, covered.

- You cannot receive multiple coverage under the plan because you are connected with more than one employer or are both and member and dependent.

- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.

- This document describes the main features of the plan. If you have any questions about the terms of the plan or about the proper payment of benefits, contact Aetna or the Benefit Fund.

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

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than two years after the deadline.

Payment of Benefits

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

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

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a healthcare provider or facility will not be accepted.

When a PCP provides care for you or a covered dependent, or care is provided by a network provider on referral by your PCP (network services or supplies), the network provider will take care of filing claims.

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ADDITIONAL INFORMATION

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 Caesarean 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 healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

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

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

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please call the Aetna Member Services telephone number on your ID card.
YOUR RIGHTS UNDER THE MENTAL HEALTH PARITY ACT

The Benefit Fund complies with federal law in that the maximum dollar amount the Benefit Fund will pay for mental health benefits is not less than the maximum dollar amount that the Benefit Fund pays for medical and surgical benefits. (See Section I.D regarding Maximum Lifetime Benefit.)

6. WHEN YOU HAVE A COMPLAINT OR AN APPEAL – AETNA APPEALS PROCESS

Commonly Used Terms:

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit. Such adverse benefit determination may be based on:

• Your eligibility for coverage;
• The results of any Utilization Review activities;
• A determination that the service or supply is experimental or investigational; or
• A determination that the service or supply is not medically necessary.

Appeal: A written request to Aetna to reconsider an adverse benefit determination.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-Service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a “Pre-Service Claim.”

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

• jeopardize your life;
• jeopardize your ability to regain maximum function;
• cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
• in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

If your claim or your request for benefits is denied, Aetna and the Benefit Fund provide for two levels of appeals as described below. The notice of an adverse benefit determination will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna’s Customer Service Unit at the toll-free phone number on your ID card.
CLAIM DETERMINATIONS

Urgent Care Claims

Aetna will make notification of an urgent care claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48-hour period given the physician to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar days claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension

Following a request for a concurrent care claim extension, Aetna will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a concurrent care claim extension.
Concurrent Care Claim Reduction or Termination

Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal.

Complaints

If you are dissatisfied with the service you receive from Aetna or want to complain about a provider, you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an appeal if Aetna gives notice of an adverse benefit determination.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your level one appeal. Your appeal may be submitted verbally or in writing and should include:

- Your name;
- Your employer’s name;
- A copy of Aetna’s notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

The notice of an adverse benefit determination will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna’s Customer Service Unit at the toll-free phone number on your ID card. You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing verbal or written consent to Aetna.

Level One Appeal

A level one appeal of an adverse benefit determination shall be provided by Aetna personnel not involved in making the adverse benefit determination.

Urgent Care Claims (May Include concurrent care claim reduction or termination)

Aetna shall issue a decision within 36 hours of receipt of the request for an appeal.

Pre-Service Claims (May Include concurrent care claim reduction or termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal.
Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.
You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.
A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative.
You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Level Two Appeal
If Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative has the right to file a level two appeal.

Urgent Care Claims (May include concurrent care claim reduction or termination)
Aetna shall issue a decision within 36 hours of receipt of the request for a level two appeal.
An Appeal of an urgent care claim shall be provided by Aetna or Company personnel not involved in making an adverse benefit determination. The Appeal must be submitted within 60 calendar days following the receipt of notice of a level one appeal.

An appeal of a Pre-Service Claim or a Post-Service Claim must be submitted within 60 calendar days following the receipt of notice of a level one appeal. Send your appeal request to Aetna, and Aetna will forward your appeal request and any additional information you have provided, along with the level one appeal file, to the Benefit Fund.

Pre-Service Claims (May include concurrent care claim reduction or termination)
The Benefit Fund shall issue a decision within 15 calendar days of receipt of the request for level two appeal.

Post-Service Claims
The Benefit Fund shall issue a decision within 30 calendar days of receipt of the request for a level two appeal.
If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

Exhaustion of Process
You must exhaust the applicable level one and level two processes of the appeal procedure before you establish any:
• litigation;
• arbitration; or
• administrative proceeding;
regarding an Adverse Determination by Aetna or any matter within the scope of the Appeals Procedure.
7. AETNA DEFINITIONS FOR MEDICAL BENEFITS

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

Aetna
Aetna Life Insurance Company

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

Behavioral Health Provider/Practitioner
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Birthing Center
A freestanding facility that meets all of the following requirements:
• Meets licensing standards.
• Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
• Is directed by at least one physician who is a specialist in obstetrics and gynecology.
• Has a physician or certified nurse midwife present at all births and during the immediate postpartum period.
• Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by an RN or certified nurse midwife.
• Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.

Co-pay, Co-payment or Co-insurance
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various co-payments, and these co-payment amounts or percentages are specified in the Schedule of Benefits.

Cosmetic or Cosmetic Surgery
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical, vision or hearing services and supplies shown as covered under this Booklet.
Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters.

Day Care Treatment
A partial confinement treatment program to provide treatment for you during the day. The hospital, psychiatric hospital or residential treatment facility does not make a room charge for day care treatment. Such treatment must be available for at least four hours, but not more than 12 hours in any 24-hour period.

Deductible
The part of your covered expenses you pay before the plan starts to pay benefits. Additional information regarding deductibles and deductible amounts can be found in the Schedule of Benefits.

Deductible Carryover
This allows you to apply any covered expense incurred during the last three months of a calendar year that is applied toward this year’s deductible to also apply toward the following year’s deductible.

Detoxification
The process by which an alcohol, intoxicated or drug-intoxicated or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:
- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

Directory
A listing of all network providers. Information is also available through Aetna’s online provider directory, DocFind.

Durable Medical and Surgical Equipment (DME)
Equipment, and the accessories needed to operate it, that is:
- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a illness or injury;
- Suited for use in the home;
- Not normally of use to people who do not have a illness or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over-bed tables, elevators, communication aids, vision aids and telephone alert systems.
Effective Treatment of a Mental Disorder
This is a program that is:
• Prescribed and supervised by a physician; and
• For a mental disorder that can be favorably changed.

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

Emergency Medical Condition
A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:
• Placing your health in serious jeopardy; or
• Serious impairment to bodily function; or
• Serious dysfunction of a body part or organ; or
• In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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

**Home Health Care Agency**

An agency that meets all of the following requirements:

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

**Home Health Care Plan**

This is a plan that provides for continued care and treatment after discharge from a hospital. The care and treatment must be:

- For the same or related condition that required the hospital stay; and
- Prescribed in writing by the attending physician within seven days from the hospital discharge; and
- An alternative to a hospital stay.

**Hospice Care**

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

**Hospice Care Program**

This is a written plan of hospice care which:

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

**Hospice Facility**

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

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

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

Hospitalization
Is necessary and continuous confinement as an inpatient in a hospital is required and a charge for room and board is made.

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

Infertile or Infertility
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:
• For a woman who is under 35 years of age: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
• For a woman who is 35 years of age or older: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury
An accidental bodily injury that is the sole and direct result of:
• An unexpected or reasonably unforeseen occurrence or event; or
• The reasonable unforeseeable consequences of a voluntary act by the person. An act or event must be definite as to time and place.

In no event does hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital or facility primarily for rehabilitative or custodial services.
Institute of Excellence (IOE)
A hospital or other facility that has contracted with Aetna to furnish services or supplies to an IOE patient in connection with specific transplants at a negotiated charge. A facility is an IOE facility only for those types of transplants for which it has signed a contract.

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

LPN
A licensed practical or vocational nurse.

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

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
c) Not primarily for the convenience of the patient, physician, other healthcare or dental provider; and
d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

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

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

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

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

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

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

**Network Provider**
A healthcare provider who has contracted to furnish services or supplies for a negotiated charge; but only if the provider is, with Aetna’s consent, included in the directory as a network provider for:

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

**Network Service(s) or Supply(ies)**
Healthcare service or supply that is:

- Furnished by a network provider; or
- Furnished or arranged by your PCP.
Night Care Treatment
A partial confinement treatment program provided when you need to be confined during the night. A room charge is made by the hospital, psychiatric hospital or residential treatment facility. Such treatment must be available at least:

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

Non-Occupational Illness
A non-occupational illness is an illness that does not:

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

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

- Is covered under any type of Workers’ Compensation law; and
- Is not covered for that illness under such law.

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

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

Non-Specialist
A physician who is not a specialist.

Non-Urgent Admission
An inpatient admission that is not an emergency admission or an urgent admission.

Occupational Injury or Occupational Illness
An injury or illness that:

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

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

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

Orthodontic Treatment
This is any:

- Medical service or supply; or
- Dental service or supply; furnished to prevent or to diagnose or to correct a misalignment:
  - Of the teeth; or
  - Of the bite; or
  - Of the jaws or jaw joint relationship;
whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

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

**Out-of-Network Provider**
A healthcare provider who has not contracted with Aetna to furnish services or supplies at a negotiated charge.

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

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

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

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

**Physician**
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
• Under applicable insurance law is considered a “physician” for purposes of this coverage;
• Has the medical training and clinical expertise suitable to treat your condition;
• Specializes in psychiatry, if your illness or injury is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
• A physician is not you or related to you.

**Pre-certification or Pre-certify**
A process where Aetna is contacted before certain services are provided, such as hospitalization or outpatient surgery, or prescription drugs are prescribed to determine whether the services being recommended or the drugs prescribed are considered covered expenses under the plan. It is not a guarantee that benefits will be payable.

**Primary Care Physician (PCP)**
This is the network provider who:
• Is selected by a person from the list of primary care physicians in the directory;
• Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician;
• Initiates referrals for specialist care and maintains continuity of patient care; and
• Is shown on Aetna’s records as the person’s PCP.

**Psychiatric Physician**
This is a physician who:
• Specializes in psychiatry; or
• Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or mental disorders.

**Recognized Charge**
Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lowest of:
• The provider’s usual charge for furnishing it; and
• The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or
  a. For non-facility charges: Aetna uses the Aetna Market Fee Schedule.
  b. For facility charges: Aetna uses the Aetna Facility Fee Schedule for the geographic area where the service is furnished.

In determining the recognized charge for a service or supply that is:
• Unusual; or
• Not often provided in the geographic area; or
• Provided by only a small number of providers in the geographic area; Aetna may take into account factors such as:
  • The complexity;
  • The degree of skill needed;
  • The type of specialty of the provider;
  • The range of services or supplies provided by a facility; and
  • The recognized charge in other geographic areas.
In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) that sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

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

R.N.
A registered nurse.

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

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

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

Rehabilitation Facility
A facility, or a distinct part of a facility which provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located and makes charges for its services.
Skilled Nursing Facility
An institution that meets all of the following requirements:

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

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

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, substance abuse or mental disorders.
Skilled Nursing Services
Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an RN or LPN within the scope of his or her license.
- The services are not custodial.

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

Specialty Care
Healthcare services or supplies that require the services of a specialist.

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

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

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

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an RN.
- Is equipped and has trained staff to handle emergency medical conditions.

Terminally Ill (Hospice Care)
Terminally ill means a medical prognosis of six months or less to live.

Urgent Admission
A hospital admission by a physician due to:

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

**Urgent Condition**
This means a sudden illness, injury or condition that:

• Is severe enough to require prompt medical attention to avoid serious deterioration of your health;

• Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;

• Does not require the level of care provided in the emergency room of a hospital; and

• Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

**Walk-in Clinic**
Walk-in Clinics are network, free-standing healthcare facilities. They are an alternative to a physician’s office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room nor the outpatient department of a hospital shall be considered a Walk-in Clinic.
SECTION II. B
DENTAL BENEFITS PROVIDED BY CIGNA

BENEFIT BRIEF

• Benefits provided by Cigna
• Each individual must select a Cigna dentist as their designated (or primary care) dentist
• Other than for emergencies, services must be performed by your designated Cigna Participating dentist
• Referrals required for some specialists
• Co-payments and limitations may apply for some procedures (excluding essential oral pediatric services to the extent required by the Patient Protection and Affordability Care Act)
• No annual maximum

Full-Time Eligibility Class I: Family Coverage for Member, Spouse and Dependent Children
Part-Time Eligibility Classes II and III: Not Covered

Note: Genesis employees and their eligible dependents are eligible for dental benefits based upon your family election.

1. WHAT THE PLAN COVERS

Covered Dental Services

Covered Dental Service means a Dental Service that:

• Is performed by, or under the direction of, the designated Participating Dental Facility, or upon referral by the Participating General Dentist to an approved Specialist and authorized by Cigna; and
• Is essential for the necessary care of the teeth and supporting structure (gums); and
• Starts and is completed while the person is insured.

Effective January 1, 2011, there is no limit on essential oral pediatric services to the extent required by the Patient Protection and Affordability Care Act.
You, your spouse and your Children are covered for the following based upon co-payments and maximums described in your Patient Charge Schedule provided to you by Cigna:

**Diagnostic/Preventive** – Typical services include four oral evaluations per year and X-rays needed to diagnose a specific injury or disease, panoramic (complete set) of X-rays once every three years, prophylaxis (cleaning) twice per year, and fluoride treatment twice per year for children up to age 19. Some services may be subject to a co-payment.

**Restorations** – Fillings subject to a co-payment.

**Crown, Bridgework and Prosthetics** – Typical services include inlays, onlays, crowns, pontics, or dentures and their repair or relining. Services provided once every five years subject to co-payments except for repair and relining of dentures once every 36 months.

**Endodontics** – Root canal treatment subject to co-payments.

**Periodontics** – Treatment of Supporting Tissues (Gum and Bone) of the Teeth. Typical services include gingivectomy, bone replacement grafts and scaling and root planning. Subject to co-payments and annual and tooth limitations.

**Oral Surgery** – Includes extraction and removal of impacted teeth, other surgical procedures and postoperative care subject to co-payments.

**Orthodontics** – Includes orthodontic treatment plan and records, interceptive orthodontic treatment, comprehensive orthodontic treatment and retention (post-treatment stabilization). Treatment for 24 months for children and for adults. Co-payments of $2,304 for children and $3,120 for adults payable over the 24-month period. Atypical cases or cases beyond 24 months require an additional payment by the patient.

**General Anesthesia/IV Sedation** –
General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedure. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures. Plan limitation for this benefit is one hour per appointment, and co-payments are based upon time intervals. There is no coverage for general anesthesia or intravenous sedation when used for the purpose of anxiety control or patient management.

**Emergency Services** – Emergency Dental Treatment means diagnostic and palliative procedures administered in the case of: (a) a dental emergency that involves acute pain, and (b) a dental condition that requires immediate treatment.
Getting Your Benefits
If you have any questions or concerns regarding your Dental Office or Dental Plan, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices or other matters, call Cigna Member Services at (800) 244-6224.

Choosing your Dentist
You and your Dependents should select a Dental Office when you become covered for dental benefits. If you did not, you must advise Cigna of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna authorizes a payment for out-of-network benefits.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the Network, Cigna will let you know and will arrange a transfer to another Dental Office.

To obtain a list of Dental Offices near you, visit Cigna’s website at www.cigna.com or call the Dental Office Locator at (800) 244-6224. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling CIGNA Member Services.

For Covered Services at your Dental Office, you will be responsible for the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees. If, on a temporary basis, there is no Network General Dentist in your Service Area, CIGNA will let you know if you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna will pay the non-Network Dentist the difference, if any, between his or her usual fee and the applicable Patient Charge.

Emergency Dental Care
An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

Emergency Care Away From Home
If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services from any General Dentist. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care. You should return to
your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. CIGNA will reimburse you the difference, if any, between the Dentist’s usual fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and X-rays to CIGNA at the address listed on the back of your Cigna ID Card.

**Emergency Care After Hours**

There is an additional charge for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable charges.

**Other Patient Charges**

Network General Dentists are typically reimbursed by CIGNA through fixed monthly payments and supplemental payments for certain procedures. Network Dentists are also compensated by the fees that you pay, as set out in your Patient Charge Schedule. There are no deductibles and no annual dollar limits for services covered by your Dental Plan. Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office’s payment policies.

Patient Charges and limitations are subject to change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

**Specialty Referrals**

When specialized dental care services are required, a Participating General Dentist must initiate the referral process.

Covered specialists include:

- pediatric dentists – dentistry for children up to age 7;
- endodontics – root canal treatment;
- periodontics – treatment of gums and bone;
- oral surgeons – complex extractions and other surgical procedures; and
- orthodontics – tooth movement.

There is no coverage for prosthodontics or other specialists not listed above.
2. WHAT IS NOT COVERED

Covered Dental Services will not include or, where applicable, no payment will be made for, any:

- services provided by a non-Network Dentist without Cigna’s prior approval (except for emergencies)
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance)
- replacement of fixed and/or removal of prosthodontic or orthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- procedures, appliances or restorations, if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact); (2) diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ), unless TMJ therapy is specially listed in your Patient Charge Schedule; or (3) restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- prescription drugs.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when Medically Necessary and provided in conjunction with Covered Dental Services performed by an Oral Surgeon or Periodontist.
- procedures or appliances for minor tooth guidance, or to control harmful habits.
- procedures or services associated with the placement or prosthodontic restoration of a dental implant.
- crowns or bridges used solely for splinting.
- resin-bonded retainers and associated pontics.
- hospitalization, including any associated incremental charges for dental services performed in a hospital.
- orthodontic services related to incremental costs associated with optional/elective materials, including, but not limited to, ceramic, clear lingual brackets, or other cosmetic appliances; orthognathic surgery and associated incremental costs; appliances to guide minor tooth movement or to correct harmful habits; services which are not typically included in orthodontic treatment; and services in progress at the time you enrolled.
- surgical removal of an impacted wisdom tooth if the tooth is not diseased, or if the removal is only for orthodontic reasons.
• the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA coverage.

• Complex Rehabilitation involving 6 or more “units” of crown and/or bridge in the same treatment plan.

**General Limitations**

No payment will be made for expenses incurred or services received:

• for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;

• for or in connection with a Sickness which is covered under any Workers’ Compensation or similar law;

• services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.

• Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.

• for charges made by a Hospital;

• to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;

• which the person would not be legally required to pay;

• when charges would not have been made if the person had no insurance;

• for care, treatment or surgery not prescribed as necessary by a Dentist;

• for or in connection with unnecessary or experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;

• all clinical lab services, pharmacy services, X-ray or imaging services, if referred by a practitioner who has a financial relationship (or whose immediate family member has a financial relationship) with the provider of those services;

• due to Injuries that are intentionally self-inflicted.

• to the extent that benefits are paid or payable for those expenses or services under any group medical plan, no-fault insurance policy or an uninsured motorist policy.
3. CIGNA’S APPEALS PROCESS FOR DENTAL BENEFITS

If your claim or your request for benefits is denied, Cigna provides for two levels of appeals as described below.

If you have a concern regarding a person, a service, the quality of care or your benefits, you can call the Cigna toll-free telephone and speak to a Cigna Customer Service representative or write to Cigna. The toll-free number and address appears on the back of your I.D. card.

Cigna will attempt to resolve the matter on your initial contact. If it needs more time to review or investigate a complaint about: (1) a denial of, or failure to pay for, a referral; or (2) a determination as to whether a benefit is covered under the Policy, it will get back to you on the same day we receive your complaint; or use the “Grievances and Appeals of Administrative and Other Matters” process described in this section.

Concerns regarding the quality of care; choice of or access to, providers; or provider network adequacy, will be forwarded to Cigna’s Quality Management Staff for review, and Cigna will provide written acknowledgment of your concern within 15 days with appropriate resolution information to follow in a timely manner.

a. Grievance and Appeals of Administrative and Other Matters

Cigna has a two-step appeals procedure to review any dispute you may have with Cigna’s decision, action, or determination. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable (or choose not) to write, you may ask to register your appeal by telephone.

Cigna will acknowledge your appeal in writing within five working days after it is received. Acknowledgments include the name, address and telephone number of the person designated to respond to your appeal, and indicate what additional information, if any, must be provided.

Level One Administrative Appeal/Grievance

You (or your representative, with your acknowledgment and consent) must submit your Level One Administrative Appeal in writing or by telephone, to the Customer Services Toll-Free Telephone Number, or the address that appears on your benefit identification card, explanation of benefits, or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving clinical appropriateness will be considered by a healthcare professional of the same or similar specialty as the care under consideration. Cigna will respond in writing with a decision within 30 calendar days after the appeal is received. This notification will include the reasons for the decision, including
clinical rationale, if applicable, as well as additional appeal rights, if any.

**Level Two Administrative Appeal**

If you are dissatisfied with Cigna’s Level One grievance decision, you may request a second review. To start a Level Two grievance, follow the same process required for a Level One Appeal. Most requests for a second review will be conducted by the Administrative Appeal Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration, as determined by Cigna’s Dentist reviewer. You may present your situation to the Committee in person or by conference call.

Cigna will acknowledge in writing that we have received your request and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

You are not obligated to grant the Committee an extension or to provide the requested information. You will be notified in writing of the Committee’s decision within five working days after the Committee meeting; and within the Committee review time frames above, if the Committee does not approve the requested coverage.

**b. Appeals of Utilization Review Decisions**

Cigna has a two-step appeals procedure to review any dispute you may have regarding a Cigna utilization review determination. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable (or choose not) to write, you may ask to register your appeal or ask for information about utilization review decisions by calling the toll-free telephone number on your benefit identification card, explanation of benefits, or claim form, Monday through Friday, during regular business hours. If calling after hours, follow the recorded instructions if you wish to leave a message.

Cigna will acknowledge your appeal in writing within five working days after we receive the appeal. Acknowledgments include the name, address, and telephone number of the person designated to respond to your appeal, and indicate what additional information, if any, must be provided.

If no decision is made within the applicable time frames described below regarding your appeal of an adverse utilization review determination, the adverse determination will be deemed to be reversed.
Level One Appeal
(Final Adverse Determination)

You (or your representative with your acknowledgment and consent) must submit your Level One appeal in writing or by telephone to the Customer Services Toll-Free Telephone Number, or the address that appears on your benefit identification card, explanation of benefits, or claim form. Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a healthcare professional of the same or similar specialty as the care under consideration. Cigna will respond in writing with a decision within 15 calendar days after it receives an appeal. If more information is needed to make the determination, Cigna will notify you in writing or request an extension of up to 15 calendar days and specify any additional information needed to complete the review. You are not obligated to grant Cigna an extension or to provide the requested information.

If you remain dissatisfied with the Level One decision of Cigna, you have the right to request an External Appeal, as well as a Level Two Appeal as described in the following paragraphs. You may also request an External Appeal application from the New York Insurance Department, toll-free, at (800) 400-8882; or at its website (www.ins.state.ny.us); or from the New York State Department of Health at its website (www.health.state.us).

Level Two Appeal

If you are dissatisfied with Cigna’s Level One appeal decision, you may request a second review. To initiate a Level Two appeal, follow the same process required for a Level One appeal. Most requests for a second review will be conducted by the Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving medical necessity or clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration, as determined by CIGNA's Dentist reviewer. You may present your situation to the Committee in person or by conference call.

For Level Two appeals, Cigna will acknowledge in writing that we have received your request and schedule a Committee review. For post-service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You are not obligated to grant the Committee an extension, or to provide the requested information. You will be notified in writing of the Committee’s decision within five working days after the Committee meeting; and within the
Committee review time frames above, if the Committee does not approve the requested coverage.

External Appeal

a. Your Right to an External Appeal
Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if Cigna has denied coverage on the basis that the service is not Medically Necessary, or is an Experimental or Investigational Treatment, you (or your representative, with your acknowledgment and consent) may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

b. Your Right to Appeal a Determination That a Service Is Not Medically Necessary
If Cigna has denied coverage on the basis that the service is not medically necessary, you may appeal to an External Appeal Agent if you satisfy the following criteria:

- The service, procedure, or treatment must otherwise be a Covered Dental Service under this Plan; and,
- You must have received a final adverse determination through the first level of CIGNA’s internal appeal process, and Cigna must have upheld the denial; or you and CO must agree in writing to waive any internal appeal.

c. Your Rights to Appeal a Determination That a Service Is Experimental or Investigational
If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following criteria:

- The service must otherwise be a Covered Dental Service under this Plan; and
- You must have received a final adverse determination through the first level of CIGNA’s internal appeal process, and Cigna must have upheld the denial; or you and CO must agree in writing to waive any internal appeal.

d. The External Appeal Process
If, through the first level of Cigna’s internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not Medically Necessary, or is an Experimental or Investigational Treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and Cigna have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. Cigna will provide an external appeal application with the final adverse determination issued through the
first level of Cigna’s internal appeal process or its written waiver of an internal appeal.

You will lose your right to an external appeal if you do not file an application for an external appeal within 45 days from your receipt of the final adverse determination from the first level plan appeal, regardless of whether you choose to pursue a second level internal appeal with Cigna.

The External Appeal Program is a voluntary program.

You may also request an external appeal application from New York State, toll-free, at (800) 400-8882; or at its website (www.ins.state.ny.us); or from our Member Services department at the toll-free telephone number on your Cigna identification card. Submit the completed application to the State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Cigna based its denial, the External Appeal Agent will share this information with Cigna in order for it to exercise its right to reconsider its decision. If Cigna chooses to exercise this right, Cigna will have three working days to amend or confirm its 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 Dentist, or Cigna. If the External Appeal Agent requests additional information, it will have five additional working days to make its decision.

The External Appeal Agent must notify you in writing of its decision within two working days.

If the External Appeal Agent overturns Cigna’s decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, Cigna will provide coverage subject to the other terms and conditions of this document. The External Appeal Agent’s decision is binding on both you and Cigna. The External Appeal Agent’s decision is admissible in any court proceeding.

Cigna will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. Cigna will also waive the fee if it determines that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.
e. **Your Responsibilities**

It is your responsibility to initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If utilization review was initiated after healthcare services have been provided, your Physician may file an external appeal by completing and submitting the “New York State External Appeal Application For Healthcare Providers to Request an External Appeal of a Retrospective Final Adverse Determination,” which will require your signed acknowledgment of the provider’s request and consent to release the medical records.

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from Cigna that it has upheld a first level denial of coverage or the date upon which you receive a written waiver of any internal appeal. Cigna has no authority to grant an extension of this deadline.

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**Complaints/Appeals to the State of New York:**

At any time in the Grievance/Appeals process you may contact the Department of Health (for medically related issues) or the Department of Insurance (for billing/contract related issues) at the following address and telephone number to register your complaint:

- **New York Department of Health Metropolitan Regional Area Office**
  - 5 Penn Plaza, 2nd Floor
  - New York, NY 10001
  - (212) 268-6306 or (800) 206-8125

  or

- **New Rochelle Area Office**
  - 145 Huguenot Street, 6th Floor
  - New Rochelle, NY 10810
  - (914) 654-7199 or (800) 206-8125

- **New York State Insurance Department**
  - One Commerce Plaza
  - Albany, NY 12257
  - (800) 342-3736

**Notice of Benefit Determination on Grievance or Appeal**

Every notice of a determination on grievance or appeal will be provided in writing or electronically and, if an adverse determination, will include:

1. the specific reason or reasons for the adverse determination including clinical rationale;
2. reference to the specific plan provisions on which the determination is based;
3. a statement that the claimant is entitled to receive, upon request and free of
charge, reasonable access to, and copies of, all documents, records, and other Relevant Information as defined; (4) a statement describing: (a) the procedures to initiate the next level of appeal; (b) any voluntary appeal procedures offered by the plan; and (c) the claimant’s right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your appeal; and (6) an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment, or other similar exclusion or limit.

In addition, every notice of a utilization review final adverse determination must include: (a) a clear statement describing the basis and clinical rationale for the denial as applicable to the insured; (b) a clear statement that the notice constitutes the final adverse determination; (c) Cigna’s contact person and his or her telephone number; (d) the insured’s coverage type; (e) the name and full address of Cigna’s utilization review agent, if any; (f) the utilization review agent’s contact person and his or her telephone number; (g) a description of the healthcare service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or Physician proposed to provide the treatment, and the developer/manufacturer of the healthcare service; (h) a statement that the insured may be eligible for an external appeal and the time frames for requesting an appeal; and (1) a clear statement written in **bolded text** that the 45-day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested; and that by choosing the request a second level internal appeal, the time may expire for the insured to request an external appeal.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the Level Two decision (or with the Level One decision for all expedited grievance or appeals and all Medical Necessity appeals). You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. To determine what options may be available to you, contact the local U.S. Department of Labor office or your state insurance regulatory agency. You may also contact the Plan Administrator.

**Relevant Information**

Relevant Information is any document, record, or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information
was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit, or the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action
You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

4. CIGNA DEFINITIONS FOR DENTAL BENEFITS

Adverse Determination
A decision by CIGNA not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and must meet the following requirements: be consistent with the symptoms, diagnosis or treatment of the condition present; conform to commonly accepted standards throughout the dental field; not be used primarily for the convenience of the member or provider of care; and not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

CIGNA
The Cigna Health organization that provides dental benefits in your state as listed on the face page of this Booklet.

Co-payment or Patient Charge
The co-payment amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

Dentist
The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any Covered Dental Services.

Participating Dental Facility
The term Participating Dental Facility means an approved dental care facility for the provision of ordinary and customary dental care, with such care to be provided at predetermined fees negotiated by Cigna.
Participating or Network Dentist/Network General Dentist
A licensed Dentist who has signed an agreement with CIGNA to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

Participating or Network Specialty Dentist
A licensed Dentist who has signed an agreement with Cigna under which he or she agrees to provide specialized dental care services upon payment authorization by Cigna Health

Patient Charge Schedule
The list provided by Cigna of Covered Services and amounts payable by you.

Service Area
The geographical area designated by CIGNA within which it shall provide benefits and arrange for dental care services.

Usual Fee
The customary fee that an individual Dentist most frequently charges for a given dental service.
SECTION II. C
PRESCRIPTION DRUGS

BENEFIT BRIEF

Prescription Drugs
- Coverage of FDA-approved prescription medications for FDA-approved indications except plan exclusions
- $10 co-pay for generic drugs and $15 co-pay for preferred brand-name drugs
- Use Participating Pharmacies
- Mandatory maintenance drug access program
- You must comply with the Benefit Fund’s Prescription Programs, including prior authorization where required

For a complete list of these programs, please call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

Full-Time Eligibility Class 1: Family Coverage for Member, Spouse and Dependent Children

Part-Time Eligibility Classes II and III: Coverage for Member Only

Note: Genesis employees and their eligible dependents are eligible for prescription benefits based upon your family election.

WHAT IS COVERED

The Benefit Fund covers drugs approved by the Food and Drug Administration (FDA) that:
- Have been approved for treating your specific condition;
- Have been prescribed by a licensed prescriber; and
- Are filled by a licensed pharmacist.

Benefits for prescriptions for FDA-approved drugs which are not approved for treatment of your condition must be submitted to the Benefit Fund’s office for consideration. Your doctor should provide detailed medical information and supporting documentation for prescribing this medication.
USING YOUR BENEFITS

To get your prescription:

• Ask your doctor to prescribe only covered medications as per the Benefit Fund’s Prescription Program
• Use Participating Pharmacies for short term medications
• Show your Health Benefits ID Card to the pharmacist when you give him or her your prescription.

There is a $10 co-pay for generic drugs, and only a $15 co-pay for preferred brand-name drugs, when you comply with the Benefit Fund’s prescription programs:

• Mandatory generic drug program
• Preferred drug list
• Mandatory maintenance drug access program
• Prior authorization for specified medications
• Quantity and day supply limitations
• Step therapy, and
• Use the Specialty Care Pharmacy for injectables and other drugs that require special handling

PRESCRIPTION DRUG PROGRAMS

For a complete list of these programs, please call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

Generic Drugs

Generic drugs are the same as brand-name drugs. The only major difference is the cost.

By law, generic drugs must contain the same active ingredients in the same quantities and be the same strength as the corresponding brand-name drug. Most importantly, they must meet the same FDA standards for safety and effectiveness.

When the doctor gives you a prescription:

• If there is a generic equivalent for a brand-name drug, you must get the generic drug. Otherwise, you will have to pay your co-pay plus the difference in cost between the brand-name drug and the generic equivalent.
• If there is no generic equivalent, your prescription will be filled with the brand-name drug.
• In rare situations, your doctor may specify the brand-name drug. In this case, your doctor must submit detailed medical information and supporting documentation to the Prescription Review Department to evaluate the clinical reasons why the brand-name drug is necessary.

Preferred Drugs

The Benefit Fund and its Pharmacy Benefit Manager have developed a list of preferred drugs known as a Preferred Drug List (PDL).

Drugs were selected based on how well they work and their safety. All
participating providers have been provided with a copy of the Preferred Drug List. It should be used when prescription medication is required. If your doctor prescribes a brand-name drug that is not preferred, you will have to pay your co-pay plus the difference in cost between the preferred drug and the non-preferred drug. If you would like a copy of the PDL, please call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

Prior Authorization for Specified Medications

You must get prior approval before benefits can be proved for prescriptions filled with certain medications. The Plan Administrator will periodically publish an updated listing of which drugs require prior authorization.

If your doctor prescribes any of those drugs, contact the Benefit Fund at (646) 473-9200. Some drugs require Prior Authorization from the Pharmacy Benefit manager. Visit our website at www.1199SEIUBenefits.org for a comprehensive list and the correct phone number to use.

NOTE: You may have to pay the entire cost of the prescription if you don’t get prior approval from the Benefit Fund. These claims will not be reimbursed.

PRESCRIPTION DRUG PROGRAMS

Quantity and Day Supply Limits

These prescription programs are intended to monitor clinical appropriateness of utilization based upon FDA guidelines. Examples of these programs are:

Proton Pump Inhibitors – You must get prior approval if your doctor prescribes one of these drugs for more than a 90-day period.

Migraine Medications – Coverage is limited to a specific quantity. Prescriptions for these medications must be in compliance with the standards and criteria established by the FDA and accepted clinical guidelines for standard of care.

Dose Optimization – A program to help members have a more convenient “once per day” prescription dosing regimen whereby prescriptions written for twice-a-day dosing may be changed to once-a-day dosing.

Personalized Medicine – A voluntary program available to Members using drugs like Tamoxifen and Warfarin to help physicians determine which drug and dosage are clinically appropriate.

Quantity Duration – Based on FDA recommended prescribing and safety information, the quantity duration rule helps Members receive the most clinically effective dosages of medication.
Specialty Care
Members must use the Specialty Care Pharmacy Program for injectables and other drugs that require special handling. Call the Benefit Fund or visit our website at www.1199SEIUBenefits.org for a listing of drugs included in this program. Specialty Care drugs are available only through this mail delivery service.

Step Therapy
Step Therapy is designed to provide safe, effective treatment while controlling prescription costs. With step therapy, you are required to try established, lower-cost, clinically appropriate alternatives before progressing to other, more costly medications, such as preferred brand names.

PROTECT YOUR CARD
Your 1199SEIU ID card is for your use only. Do not leave your card with your pharmacist. Show it to the pharmacist when ordering your prescription and make sure it is returned to you before you leave the store.

If your card is lost or stolen, immediately report it to the Benefit Fund at (646) 473-9200. If you think someone is fraudulently using your card, call the Benefit Fund’s fraud hotline at (646) 473-6148 or visit our website at www.1199SEIUBenefits.org.

USE A PARTICIPATING PHARMACY
For a list of Participating Pharmacies, call the Benefit Fund’s Member Services Department at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

If you use a Non-Participating Pharmacy, you will have to:

- Pay for your prescription when it is filled;
- Call the Benefit Fund’s Member Services Department for a Prescription Reimbursement Claim Form, or download it from the Benefit Fund’s website at 1199SEIUBenefits.org; and
- Complete this form and send it along with an itemized paid receipt for your prescription to the address indicated on the form.

You will only be reimbursed up to the Benefit Fund’s Schedule of Allowances.
FILLING YOUR PRESCRIPTIONS

For Short-Term Illnesses:
If you need medication for a short period of time, such as an antibiotic, go to your local Participating Pharmacy to have your prescription filled.

For Chronic Conditions:
The Benefit Fund’s Mandatory Maintenance Drug Access Program – The 90-Day Rx Solution
If you have a chronic condition and are required to take the same medication on a long term basis, you must fill your prescription through the Benefit Fund’s mandatory maintenance drug access program, The 90-Day Rx Solution.

This program requires that you order medications that you take on an ongoing basis in 90-day supplies. For your convenience, your medication will be delivered directly to you at your choice of address.

If you are currently taking a maintenance medication, ask your doctor for a 90-day prescription (with 3 refills) and fill it either by:
- Mailing the prescription to the Benefit Fund’s mail order pharmacy, where it will normally be delivered within eight days; or
- Taking it to one of the designated pharmacies in New York or New Jersey.

For new maintenance medications, ask your doctor for two prescriptions: one for a 30-day supply (with one refill) and another for a 90-day supply (with 3 refills) that can be filled through the maintenance drug access program once you know that the medication works for you.

Call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org for the locations of pharmacies that participate in the maintenance drug access program, for a mail order form, or to determine if the drug that you are taking is a maintenance medication.

COORDINATING PRESCRIPTION DRUG BENEFITS
If your spouse is covered for prescription medication under another health care plan, that plan is primary. The Benefit Fund is the secondary plan for your spouse and may provide coverage for any copayments or deductibles that your spouse may incur up to the Benefit Fund’s Schedule of Allowances.

Although your spouse’s name will appear on your ID Card, he or she must use their primary prescription insurer first. Participating Pharmacies will not fill prescriptions for your spouse through the use of this ID card.
WHAT’S NOT COVERED

• Over the counter drugs (except for diabetic supplies)
• Over-the-counter vitamins
• Nonprescription items such as bandages or heating pads – even if your physician recommends them
• Prescriptions for drugs not approved by the FDA for the treatment of your condition
• Cost differentials for drugs that are not approved through the Benefit Fund’s Prescription Drug Program
• Experimental drugs
• Non-sedating antihistamines
• Migraine medication in excess of FDA guidelines for strength, quantity and duration
• Medications for cosmetic purposes
• Proton pump inhibitors in excess of a 90-day supply for FDA approved indications by diagnosis
• Cold and Cough Prescription Products
• Oral Erectile Dysfunction agents (except for penile functional rehabilitative therapy for up to six-months immediately following prostatic surgery).
• All general exclusions listed in Section VII.D.

Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.