BENEFIT PLAN

Prepared Exclusively For
Union County Educational Services Commission

Open Access Managed Choice New Jersey Educator Health Plan

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

aetna™

Preferred Provider Organization (PPO) Medical Plan

Booklet-certificate

Prepared exclusively for:

Policyholder:	Union County Educational Services Commission
Group policy number:	GP-175429
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Policyholder situs	New Jersey
Group policy effective date:	July 1, 2021
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Plan issue date:	July 1, 2021

This Certificate is not in place of insurance for Worker's Compensation. This certificate is governed by applicable federal law and the laws of New Jersey.

Underwritten by Aetna Life Insurance Company

Welcome

Thank you for choosing **Aetna**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Aetna** plan for in-network and out-of-network coverage.

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

The third document is the group policy between **Aetna Life Insurance Company** ("**Aetna**") and the policyholder. Ask the policyholder if you have any questions about the group policy.

Oh, and each of these documents may have amendments attached to them. They change or add to the documents they're part of.

Where to next? Flip through the table of contents or try the *Let's get started!* section right after it. The *Let's get started!* section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan for in-network and out-of-network coverage.

Table of Contents

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents.
- When we say "us", "we", and "our", we mean **Aetna**.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical medical language that is familiar to medical **providers**. If you need help with any of the terms, call the Member Services toll-free number on your ID card.

What your plan does – providing covered benefits

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

This plan provides network and out-of-network coverage for medical, vision and pharmacy insurance coverage.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered in-network

Your in-network coverage:

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

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

   So what are **eligible health services**? They are health care services that meet these three requirements:
   - They are listed in the *Eligible health services under your plan* section.
   - They are not carved out in the *What your plan doesn't cover – some eligible health service exceptions* section. (We refer to this section as the "exceptions" section.)
   - They are not beyond any limits in the schedule of benefits.

2. Aetna's network of **providers**

   Aetna's network of physicians, **hospitals** and other health care **providers** are there to give you and your dependents the care you and your dependents need. You and your dependents can find **network providers** and see important information about them most easily on our online **provider directory**. Just log into your Aetna secure member website at www.aetna.com.

   You and your dependents are encouraged to choose a **primary care physician** (we call that physician your **PCP**) to oversee your and your dependents' care. Your and your dependents' **PCP** will provide your and your dependents routine care, and send you and your dependents to other **providers** when you and your dependents need specialized care. You and your dependents don't have to access care through your and your dependents' **PCP**. You and your dependents may go directly to network **specialists** and **providers** for **eligible health services**. Your plan often will pay a bigger share for **eligible health services** that you and your dependents get through your and your dependents' **PCP**, so choose a **PCP** as soon as you and your dependents can.

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

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

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

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

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

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

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

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

5. **Disagreements**

   We know that people sometimes see things differently.

   The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an "independent utilization review organization" or IURO for short, will make the final decision for us.

   For more information see the *When you disagree - claim determination procedures/complaints and appeals* section.

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

The section above told you and your dependents how your plan works while you and your dependents are covered in-network. You and your dependents also have coverage when you and your dependents want to get your and your dependents' care from **providers** who are not part of the **Aetna** network. It's called out-of-network coverage.

Your and your dependents' out-of-network coverage:

- Means you and your dependents can get care from **providers** who are not part of the **Aetna** network**.**
- Means you and your dependents may have to pay for services at the time that they are provided. You and your dependents may be required to pay the full charges and may be responsible to submit a claim for reimbursement to us that you paid directly to a **provider.**
- Means that when you and your dependents use out-of-network coverage, it is your and your dependents' responsibility to start the **precertification** process with **providers**.
- Means you and your dependents will pay a higher cost share when you and your dependents use an **out-of-network provider**.

You will find details on:

- **Precertification** requirements in the *Medical necessity and precertification requirements* section.
- **Out-of-network providers** and any exceptions in the *Who provides the care* section.
- Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

How to contact us for help

We are here to answer your and your dependents' questions. You and your dependents can contact us by logging onto the Aetna secure member website at www.aetna.com.

Register for Aetna member website, our secure Internet access to reliable health information, tools and resources. Aetna member website online tools will make it easier for you and your dependents to make informed decisions about health care, view claims, research care and treatment options, and access information on health and wellness.

You and your dependents can also contact us by:

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

Your identification (ID) card

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

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

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

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

The policyholder decides and tells us who is eligible for health care coverage.

When you can join the plan

As an employee you can enroll yourself and your dependents:

- At the end of any waiting period the policyholder requires
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

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

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

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your "dependents".)

- Your legal spouse, including a civil union partner as defined by New Jersey State law. We also mean civil union or civil union partner when we talk about:
  - Husband/wife (spouse)
  - Family/immediate family
  - Dependent
  - Next of kin
- We mean civil union when we talk about:
  - Marriage
  - Widow/widower/widowed
- Your domestic partner established in New Jersey prior to February 19, 2007 as evidenced by a copy of an Affidavit of Domestic Partnership filed with the local registrar and marked as "filed".
- A domestic partnership providing all of the rights and benefits of marriage valid in another state will be valid for this benefit plan.
- Your dependent children – your own or those of your spouse or domestic partner
  - The children must be under 26 years of age, and they include:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption
    - Foster children, including any children placed with you or your spouse or your domestic partner for proposed adoption
    - Children you or your spouse or your domestic partner are responsible for under a qualified medical support order or court-order (whether or not the child resides with you or your spouse or your domestic partner and whether or not the child resides inside the **service area**)
    - Children you or your spouse or domestic partner are responsible for under court-order

- Grandchildren in your or your spouse's or domestic partner's court-ordered custody
- Any other child with whom you or your spouse or your domestic partner have a parent-child relationship
- Any unmarried dependent child or dependent child who is not in a civil union or a domestic partnership age 26 and over but under 31 years of age, chiefly dependent upon you or your spouse or domestic partner for support and maintenance
- Any unmarried dependent child or dependent child who is not in a civil union or a domestic partnership age 26 and over but under 31 years of age, chiefly dependent upon you or your spouse or domestic partner for support and maintenance, and attending a recognized college or university, trade, or secondary school on a full-time and part-time basis

Coverage may be continued for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Your or your dependent's eligibility for Medicaid shall not prohibit eligibility for, or the provision of, benefits under this **certificate**.

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 30 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 30 days of the date of your marriage.
- A domestic partner – If you enter into a domestic partnership valid in another state, you can put your domestic partner on the plan.
  - We must receive your completed enrollment information not more than 30 days after the date of enter into the domestic partnership
  - Ask the policyholder when benefits for your domestic partner will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 30 days of the date of entering into the domestic partnership.
- A newborn child - Your newborn child is covered on your health plan for the first 60 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 60 days.
- An adopted child - A child or a child who is placed with you for adoption – A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete. Placed for adoption means you or your spouse or your domestic partner have legal obligation for all or part of the support of a child in anticipation of adoption of the child. A child who is placed for adoption will be treated as a dependent from the date the child was placed for adoption.
  - To keep your adopted child covered, we must receive your completed enrollment information within 30 days after the adoption.
  - If you miss this deadline, your adopted child will not have health benefits after the first 30 days.

- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 30 days after the date of your marriage with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as (excluding the addition of a dependent as addressed in *Adding a new dependent provision*):

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other health plan of any covered dependent
- Your spouse or domestic partner covered you and your other eligible dependents under another health plan; and now that other coverage has ended for reasons other than gross misconduct

We must receive your completed change form from you within 31 days of the date of the above change in status.

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another health plan, and now that other coverage has ended.
  - You previously declined coverage in writing.
  - You had COBRA, and now that coverage has ended.
- When a court orders that you cover a current spouse or domestic partner or a minor child on your health plan
- You or your dependents lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.

We must receive your completed enrollment information within 31 days of the date of the event or date on which you no longer have the other coverage mentioned above. However, the completed enrollment form may be submitted within 60 days of the event when:

- You lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You become eligible for state **premium** assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan

Effective date of coverage

- Your coverage will be in effect as of the date you become eligible for health benefits.
- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of domestic partnership valid in another state, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

Medical necessity and precertification requirements

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

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

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

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

Medically necessary; medical necessity

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

The **medical necessity** requirements are stated in the *Glossary* section, where we define "**medically necessary, medical necessity**." That is where we also explain what our medical directors or their **physician** designees consider when determining if an **eligible health service** is **medically necessary**.

Precertification (read this provision carefully to learn how to avoid possible benefit reductions)

You and your dependents need pre-approval from us for some **eligible health services**. Pre-approval is also called **precertification**.

Precertification is not required for **substance use disorders** treatment for the first 180 days of treatment.

In-network

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

Out-of-network

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

Precertification should be secured within the timeframes specified below. For **emergency services**, **precertification** is not required, but you should notify us within the timeframes listed below. To obtain **precertification**, call us at the telephone number listed on your ID card. This call must be made:

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

We will provide a written notification to you and your dependents and your and your dependents' **physician** of the **precertification** decision**,** where required by state law. If the **precertified** services are approved**,** the approval is valid for 180 days as long as you and your dependents remain enrolled in the plan**.**

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

If **precertification** determines that the **stay** or services and supplies are not **covered benefits**, the notification will explain why and how our decision can be appealed. You, your dependents or your **provider** may request a review of the **precertification** decision. See the *When you disagree - claim decisions and appeals procedures* section.

What types of services require precertification?

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

Inpatient services and supplies
Stays in a **hospital**
Stays in a **skilled nursing facility**
Stays in a **rehabilitation facility**
Stays in a **hospice** facility
Stays in a **residential treatment facility** for treatment of **mental disorders**
Stays in a **residential treatment facility** for treatment of **substance use disorder** beginning on the 181st day of the plan year whether the days are consecutive or intermittent partial days or full days
Bariatric surgery (obesity)

Outpatient services and supplies
Applied behavior analysis
Cosmetic and reconstructive surgery
Non-emergency transportation by fixed wing airplane
Intensive outpatient program (IOP) – **mental disorder** diagnoses
Intensive outpatient program (IOP) – **substance use disorders** diagnoses beginning on the 181st day of the plan year whether the days are consecutive or intermittent, partial days or full days
Partial hospitalization treatment – **mental disorder** diagnoses
Partial hospitalization treatment – **substance use disorders** diagnoses beginning on the 181st day of the plan year whether the days are consecutive or intermittent, partial days or full days
Psychological testing/neuropsychological testing
Transcranial magnetic stimulation (TMS)

Certain **prescription drugs** are covered under the medical plan when they are given to you and your dependents by your and your dependents' **physician** or health care facility. The following information applies to these **prescription drugs**:

For certain drugs, your and your dependents' provider needs to get approval from us before we will cover the drug. This is called **precertification**. Sometimes the requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary.**

Contact us or go online to get the most up-to-date **precertification** requirements.

How do you get a medical exception?

Sometimes you and your dependents or your and your dependents' **prescriber** may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. Any exception is based upon an individual and is a case-by-case decision that will not apply to other members.

Eligible health services under your plan

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

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

For example,

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

You can find out about these exceptions in the *What your plan doesn't cover some eligible health service exceptions* section, and about the limitations in the schedule of benefits.

Important note:
Sex-specific **eligible health services** are covered when medically appropriate, regardless of identified gender.

We've grouped the health care services below to make it easier for you to find what you're looking for.

Preventive care and wellness

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

Important notes:

1. You will see references to the following recommendations and guidelines in this section:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - Health Resources and Services Administration
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

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

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

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

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

Routine physical exams

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings by blood lead measurement for lead poisoning for children, including:
  - Confirmatory blood lead testing, as specified by the New Jersey Department of Health
  - Medical evaluation
  - Any necessary medical follow-up treatment for lead poisoned children
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns:
  An initial **hospital** checkup
  Hearing loss screenings by appropriate electophysiologic screening measures
  Periodic monitoring for delayed onset hearing loss

Health wellness promotion programs

Eligible health expenses include charges made in a health promotion program through health wellness examinations and counseling for the following services. These services are recommended at certain time periods of your or your dependents' life which are shown on your schedule of benefits.

- Blood tests to determine:
  - Blood hemoglobin
  - Blood glucose
  - Blood pressure
  - Blood cholesterol
- Stool examination for the presence of blood
- Colon exams:
  - A left-sided colon examination of 35 to 60 centimeters
  - A routine diagnostic examination, including but not limited to, a digital rectal examination and a prostate-specific antigen test
- A glaucoma eye test
- A pap smear
- A mammogram
- A digital tomosynthesis, if you are age 40 or older
- Recommended immunizations
- Lifestyle behavior counseling including:
  - Smoking control
  - Nutrition and diet recommendations
  - Exercise plans

- Lower back protection
- Weight control
- Immunizations practices
- Breast self-examination
- Testicular self-examination
- Seatbelt usage in motor vehicles

Preventive care immunizations

Eligible health services include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the New Jersey Department of Health and Senior Services.

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

Well woman preventive visits

Eligible health services include your and your dependents' routine:

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

Preventive screening and counseling services

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

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

- **Substance use disorders**
  Eligible health services include the following screening and counseling services to help prevent or reduce the **substance use disorders**:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment

Eligible health services include the following screening and counseling services to help you and your dependents to stop the use of tobacco products:

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

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

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

- **Sexually transmitted infection counseling**
  Eligible health services include the counseling services to help you and your dependents prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**
  Eligible health services include counseling and evaluation services to help you or your dependents assess whether or not you or your dependents are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- A digital tomosynthesis, if you are age 40 or older
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Computed tomography colongraphy
- Lung cancer

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

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

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

Prenatal care

Eligible health services include your or your dependents' routine prenatal physical exams as preventive care, which is the initial and subsequent history and physical exam such as:

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

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

Important note:
You should review the benefit under *Eligible health services under your plan- Maternity and related newborn care* and the *What your plan doesn't cover – some eligible health service exceptions* sections of this booklet-certificate for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

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

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

Breast pump supplies and accessories

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

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

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

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

Devices

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

Voluntary sterilization

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

Important note:
See the following sections for more information:

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

Physicians and other health professionals

Physician services

Eligible health services include services by your or your dependents' **physician** to treat an **illness** or **injury**. You and your dependents can get those services:

- At the **physician's** office
- In your or your dependents' home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine** and/or **telehealth**

Important note:
Your plan covers **telemedicine** and/or **telehealth** only when you get your consult through a **provider** who has contracted with **Aetna** to offer these services. All in-person office visits covered with a **behavioral health provider** are also covered if you use **telemedicine** and/or **telehealth** instead. **Telemedicine** and/or **telehealth** is not the same as an office visit and may have different cost sharing. See the schedule of benefits for specific plan details.

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Physician surgical services

Eligible health services include the services of:

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

Alternatives to physician office visits

Walk-in clinic

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

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

Hospital and other facility care

Hospital care

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

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

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

Anesthesia and hospital charges for dental care

Eligible health services are provided to you and your dependents if severely disabled and requiring dental services, or to a covered dependent child age 5 or under who requires dental services:

- General anesthesia and hospitalization
- A medical condition requiring hospitalization or general anesthesia, regardless of where dental services are provided

Alternatives to hospital stays

Outpatient surgery and physician surgical services

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

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

Home health care

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

- You or your dependents are homebound.
- Your and your dependent's **physician** orders them and develops a plan of care with a home health care **provider**. This plan of care will be reviewed periodically and approved by your or your dependent's **physician.**
- The services take the place of the needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your or your dependent's home.

- The services are a part of a **home health care plan**.
- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.
- If you and your dependents are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.
- Home health aide services are provided under the supervision of a registered nurse.

Medical social services are provided by or supervised by a **physician** or social worker.

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

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

Hospice care

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

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

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

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

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

Outpatient private duty nursing

Eligible health services include private duty nursing care provided by an **R**.**N**. or **L**.**P**.**N**. for non-hospitalized acute **illness** or **injury** if your or your dependent's condition requires skilled nursing care and visiting nursing care is not adequate.

Skilled nursing facility

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

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

- **Room and board**, up to the **semi-private room rate**
- Infusion therapy that is administered during a **stay**
- Services and supplies that are provided during your or your dependent's **stay** in a **skilled nursing facility**

Emergency services and urgent care

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

As always, you and your dependents can get emergency services and urgent care from **network providers**. However, you can also get emergency services and urgent care from **out-of-network providers**.

Your and your dependent's coverage for **emergency services** and treatment of an urgent condition from **out-of-network providers** ends when **Aetna** and the attending **physician** determine that you or your dependents are medically able to travel or to be transported to a **network provider** if more care is needed.

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

In case of a medical emergency

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

Non-emergency condition

If you and your dependents go to an emergency room for what is not an **emergency medical condition**, the plan may not cover those expenses. See the schedule of benefits and the *exception- Emergency services and urgent care* sections for specific plan details.

In case of an urgent condition

Urgent condition

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

Non-urgent care

If you and your dependents go to an **urgent care facility** for what is not an **urgent condition,** the plan may not cover those expenses. See the *exception –Emergency services and urgent care* section and the schedule of benefits for specific plan details.

Specific conditions

Autism spectrum disorder or other pervasive developmental disabilities

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

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

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

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

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

If your dependent:

- Is eligible for early intervention services through the New Jersey Early Intervention System
- Has been diagnosed with autism or other developmental disability
- Receives physical therapy, occupational therapy, speech therapy, and applied behavior analysis or related structured behavior services

the portion of the family cost share related to such services is an **eligible health service**.

Birthing center

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

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

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

Diabetic equipment, supplies and education

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin preparations
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Injectable glucagons
- Equipment
  - External insulin pumps including insulin infusion devices
  - Blood glucose monitors without special features, unless required due to legal blindness

- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training including information on proper diet. Such dietary education must be provided by a network dietician registered by a nationally recognized professional association of dietitians or a heath professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators. If a person is diagnosed with significant changes resulting in change in self-management, any appropriate re-education or refresher training must be provided by a network dietician registered by a nationally recognized professional association of dietitians or a heath professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators.

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

Family planning services – other

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

- Voluntary sterilization for males
- Abortion

Infertility treatment

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

- To diagnose the underlying medical cause of **infertility** including up to 12 intrauterine insemination (IUI) procedures for female members without a male partner as limited under the definition of **infertility**. **Eligible health services** are dependent on age and prior care received.

Once diagnosed as **infertile** you could be eligible for the following expenses:

- Artificial insemination with ovulation induction with no limit on the number of cycles
- Assisted reproductive technology (ART)
- **Surgery** needed to treat the underlying medical cause of **infertility**.

For help using your infertility health care services you may enroll with our National infertility unit. To enroll you can reach our dedicated national **infertility** unit at 1-800-575-5999.

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

- You are covered under this plan as an employee or as a covered dependent.
- There exists a condition that:
  - Is demonstrated to cause the disease of **infertility.**
  - Has been recognized by your or your partner's **physician** or **infertility specialist** and documented in your or your partner's medical records.
- You or your partner are unable to carry a pregnancy to live birth.
- You or your partner have not had a voluntary sterilization with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You or your partner do not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.

- You or your partner have clinical need to move on to **ART** procedures based on our clinical policy bulletin and:
  - Previous services did not result in a documented fetal heartbeat.
  - The infertile female is 45 years of age or younger and has not reached the limit of 4 completed egg retrievals where the covered person's cost is covered by insurance plans or programs offered or administered by the **policyholder** through **Aetna** or an affiliated company. An infertile female over 45 years of age is not eligible for egg retrievals.
    - ART services include, but are not limited to:
      - In vitro fertilization (IVF)
      - Zygote intrafallopian transfer (ZIFT)
      - Gamete intrafallopian transfer (GIFT)
      - Cryopreserved embryo transfers (Frozen Embryo Transfers)
      - Intracytoplasmic sperm injection (ICSI) or ovum microsurgery
      - Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
      - Charges associated with obtaining the spouse's sperm for **ART** services, when the spouse is also covered under this plan.
      - The procedures are done while not confined in a **hospital** or any other facility as an inpatient.

- You or your partner have met the requirement for the number of months trying to conceive:

You are	**Number of months of unprotected timed sexual intercourse:**
A female under 35 years of age with a male partner	12 months or more
A female under 35 years of age without a male partner	Number of months of unprotected timed sexual intercourse does not apply. The female must have 12 failed attempts of intrauterine insemination under medical supervision.
A female 35 years of age or older with a male partner	6 months or more
A female 35 year of age or older without a male partner	Number of months of unprotected timed sexual intercourse does not apply. The female must have 6 failed attempts of intrauterine insemination under medical supervision.

- If you have been diagnosed with premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services through age 45 regardless of FSH level

Fertility preservation

Fertility preservation involves the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use. You or your partner are eligible for fertility preservation only when you or your partner:

- Are believed to be fertile
- Have planned services that will result in **infertility** such as:
  - Chemotherapy
  - Pelvic radiotherapy
  - Other gonadotoxic therapies
  - Ovarian or testicular removal

Along with the eligibility requirements above, you are eligible for fertility preservation benefits if, for example:

- You, your partner or dependent child are planning cancer treatment that is demonstrated to result in **infertility**. Planned cancer treatments include:
  - Bilateral orchiectomy (removal of both testicles).
  - Bilateral oophorectomy (removal of both ovaries).
  - Hysterectomy (removal of the uterus).
  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**.
- The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below:

You are	**You need to have an unmedicated day 3 FSH test done within the past:**	**The results of your unmedicated day 3 FSH test:**
A female under 35 years of age	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs.
A female 35 years of age or older	6 months	**If you are less than age 40**, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. **If you are age 40 and older**, must be less than 19 mIU/mL in all prior tests to use your own eggs.

Eligible health services for fertility preservation will be paid on the same basis as other ART services benefits for individuals who are **infertile**.

Our National Infertility Unit (NIU) is here to help. It is staffed by a dedicated team of registered nurses and **infertility** coordinators with expertise in all areas of **infertility** who can help:

- Enroll in the **infertility** program.
- Assist with **precertification** of **eligible health services**.
- Coordinate **precertification** for ART services and fertility preservation services when these services are **eligible health services.** Your **provider** should obtain **precertification** for fertility preservation services through the NIU either directly or through a reproductive endocrinologist.
- Evaluate medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.
- Determine whether ART services and fertility preservation services are **eligible health services**.
- Case manage for the provision of ART services and fertility preservation services for an eligible covered person.

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

Jaw joint disorder treatment

Eligible health services include the diagnosis and surgical treatment of **jaw joint disorder** by a **provider** which includes:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- Involving the relationship between the jaw joint and related muscle and nerves such as myofascial pain dysfunction (MPD)

Maternity and related newborn care

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

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

We provide such coverage subject to the following:

- The attending **physician** prescribes inpatient care
- The mother must request the inpatient care.

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

Mental health treatment

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

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

- 23 hour observation
- Peer counseling support by a peer support specialist
  - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a Behavioral health provider.

Substance use disorders treatment

Eligible health services include the treatment of **substance use disorders** and **detoxification** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility, physician**, medical addictionologist or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate** and other services and supplies that are provided during your or your dependent's **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility.** Treatment of **substance use disorder** in a general medical **hospital** is only covered if you or your dependents are admitted to the **hospital's** separate **substance use disorders** section or unit, unless you are admitted for the treatment of medical complications of **substance use disorders**. Services and supplies will include the following:
  - Lodging and dietary services
  - Psychologist services
  - Nurse services
  - Certified addictions counselor and trained staff services
  - Psychiatric, psychological and medical laboratory testing and drugs
  - Radiological services
  - Medicines
  - Equipment use and supplies

  for the treatment of **substance use disorders** .

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

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** and/or **telehealth** consultation)
  - Individual, group and family therapies for the treatment of **substance use disorders**
  - Other outpatient **substance use disorders** treatment such as:
    - Outpatient detoxification
    - **Partial hospitalization treatment** provided in a **facility** or program for treatment of **substance use disorders** provided under the direction of a **physician**. These days will count as inpatient treatment.
    - **Intensive outpatient program** provided in a **facility** or program for treatment of **substance use disorders** provided under the direction of a **physician**. These days will count as inpatient treatment.
    - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance use**, including administration of medications.
    - Treatment of withdrawal symptoms
    - 23 hour observation
    - Peer counseling support by a peer support specialist
      - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a Behavioral health provider.

Obesity surgery

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

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

Your or your dependent's doctor will request approval from us in advance of your or your dependent's obesity surgery. We will cover charges made by a **network provider** for the following outpatient weight management services**:**

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

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

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a **physician**, a dentist and **hospital**:

- Non-surgical treatment of infections or diseases.
- Surgery needed to:
  - Treat a fracture, dislocation, or wound.
  - Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **Hospital** services and supplies received for a **stay** required because of your or your dependent's condition.
- Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your or your dependent's teeth must be free from decay or in good repair, and are firmly attached to your or your dependent's jaw bone at the time of your or your dependent's **injury**.
  - Other body tissues of the mouth fractured or cut due to **injury.**
- Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.
  - An in-mouth appliance used in the first course of **orthodontic treatment** after an **injury**.

- Accidental **injuries** and other trauma. Oral **surgery** and related dental services to return sound natural teeth to their pre-trauma functional state. These services must take place no later than 24 months after the **injury**.
    - Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.
    - If a child needs oral **surgery** as the result of accidental **injury** or trauma, **surgery** may be postponed until a certain level of growth has been achieved.

Pregnancy complications

Eligible health services include services and supplies from your and your dependents' **provider** for pregnancy complications.

Pregnancy complications means problems caused by pregnancy that pose a significant threat to the health of the mother or baby, including:

- Hyperemesis gravidarum (pernicious vomiting of pregnancy); toxemia with convulsions; severe bleeding before delivery due to premature separation of the placenta from any cause; bleeding after delivery severe enough to need a transfusion or blood
- Amniotic fluid tests, analyses, or intra-uterine fetal transfusion made for Rh incompatibility
- An emergency medical cesarean section due to pregnancy complications
- Miscarriage if not elective or therapeutic

The plan does not cover a scheduled or non-emergency cesarean delivery.

Reconstructive surgery and supplies

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

- Your or your dependent's **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast and treatment of physical complications of all stages of the mastectomy, including lymphedema and prostheses. The following coverage is provided following a mastectomy:
    - A minimum of 72 hours of inpatient care following a modified radical mastectomy
    - A minimum of 48 hours of inpatient care following a simple mastectomy
    - A shorter length of **stay**, if you or your dependents in consultation with the **physician** determines that a shorter length of **stay** is **medically necessary**
- Your or your dependent's **surgery** is to implant or attach a covered prosthetic device.
- Your or your dependent's **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
    - The defect results in severe facial disfigurement or major functional impairment of a body part.
    - The purpose of the **surgery** is to improve function.
- Your or your dependent's **surgery** is needed because treatment of your or your dependent's **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your or your dependent's **surgery** will improve function.

Transplant services

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

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T-Cell receptor therapy for FDA approved treatments

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as **Institutes of Excellence™ (IOE) facilities** in your **provider directory**.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the **IOE facility** we designate to perform the transplant you need. You may also get transplant services at a non-**IOE facility,** but your cost share will be higher.

Important note:

- Many pre and post transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the National Medical Excellence Program® (NME) all medical services must be managed through the NME program so that you receive the highest level of benefits at the appropriate facility. This is true even if the **eligible health service** is not directly related to your transplant.

Wilm's Tumor

Eligible health services include outpatient and inpatient services including the expenses for the treatment of Wilm's tumor:

- Autologous bone marrow transplants when standard chemotherapy is unsuccessful.
- Treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants
- Peripheral blood stem cell transplants when performed by institutions approved by the National Cancer Institute or identified in the guidelines of the American Society of Clinical Oncologists.

Specific therapies and tests

Acupuncture

Eligible health services include acupuncture when performed by a physician including an acupuncturist licensed by the Acupuncturist Licensing Board if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.
- To alleviate chronic pain or to treat:
  - Postoperative and chemotherapy-induced nausea and vomiting
  - Nausea of pregnancy
  - Postoperative dental pain
  - Temporomandibular disorders (TMD)
  - Migraine headache

    Pain from osteoarthritis of the knee or hip (adjunctive therapy)

Outpatient diagnostic testing

Diagnostic complex imaging services

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

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including **Magnetic resonance spectroscopy (MRS),** Magnetic resonance venography (MRV) and Magnetic resonance angiogram (*MRA*)
- Nuclear medicine imaging including Positron emission tomography (PET) scans

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

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

Chemotherapy

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

Orally-administered anti-cancer prescription drug services

Eligible health services include orally administered anticancer medications that are used to kill or slow the growth of cancerous cells no less favorably than coverage for intravenously administered or injected cancer medications covered by this plan.

Outpatient infusion therapy

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

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **physician** in his/her office
- A home care **provider** in your or your dependent's home

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

Certain infused medications may be covered under the outpatient **prescription drug** coverage. You or your dependents can access the list of **specialty prescription drugs** by contacting Member Services or by logging onto the Aetna member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this certificate.

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

Outpatient radiation therapy

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

- Radiological services
- Gamma ray
- Accelerated particles

- Mesons
- Neutrons
- Radium

Short-term cardiac and pulmonary rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

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

Short-term rehabilitation services

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

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

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

Short-term rehabilitation services have to follow a specific treatment plan, ordered by your or your dependent's **physician**.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

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

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

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

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 covered. The limitations on therapy services do not apply to the diagnosis and treatment of autism or other developmental disabilities or to mental disorders which will be paid subject to the same terms and conditions as any other **illness**.

Therapeutic manipulation

Eligible health services include therapeutic manipulation to correct a muscular or skeletal problem.

Your or your dependent's **provider** must establish or approve a treatment plan that details the treatment, and specifies frequency and duration.

Habilitation therapy services

Habilitation therapy services are services that help you and your dependents keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).
Eligible health services include habilitation therapy services your **physician** prescribes. The services have to be performed by:

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

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

Outpatient physical, occupational, and speech therapy

Eligible health services include:

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

Specialty prescription drugs

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

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

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

Certain injected and infused medications may be covered under the outpatient **prescription drug** coverage. You can access the list of **specialty prescription drugs** by contacting Member Services or by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this certificate.

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

Other services

Ambulance service

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

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

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

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

Clinical trial therapies (experimental or investigational)

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

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

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

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

Clinical trials (routine patient costs)

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

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services

    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy
  - For those approved by the Departments of Veterans Affairs, Defense or Energy, the study or investigation must have been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines:
    - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health
    - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

Durable medical equipment (DME)

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

Coverage includes:

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

Your plan only covers the same type of **DME** that Medicare covers. But there are some **DME** items Medicare covers that your plan does not. We list examples of those in the *What your plan doesn't cover – some eligible health service exceptions* section.

Hearing aids and exams

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

Hearing aid means:

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

Hearing aid services are:

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

Home hemophilia treatment

Eligible health services include home treatment of bleeding disorders associated with hemophilia. The home treatment must be provided by a "designated" health care **provider.** A designated health care **provider** means a **provider** approved by the New Jersey Department of Banking and Insurance to contract with carriers for the purpose of rendering services for the home treatment of bleeding episodes associated with hemophilia.

Loss of Designated Status

When a designated health care provider loses their designation, we shall not continue to refer you and your dependents to that health care **provider**. If you and your dependents have been using such a **provider**, we will continue to provide services at a network level until:

- A new designated health care provider arrangement is made or
- Four months following the date of the loss of designation, whichever occurs first

We shall not be required to continue to provide services at a network level when the **provider's** loss of designation is the result of

- Revocation or surrender of a license, permit or registration
- Suspension of a license, permit or registration that cannot be corrected by reinstatement within 45 days following the date of the suspension, except as may be necessary for us and the **provider** to transition care to another designated health care provider

Termination of the Agreement

In the event that we or a designated health care provider terminates their agreement, we shall continue to provide services at a network level until:

- A new designated health care provider arrangement is made or
- Four months following the date of the loss of designation, whichever occurs first

The requirements above shall not apply when the agreement terminates on the basis of:

- Breach
- Fraud
- Determination by our medical director that the **provider** is an imminent danger to you and your dependents and others

whether such breach, fraud or imminent harm is related to the provision of services or supplies for home hemophilia treatment, or other services and supplies for which **Aetna** and the **provider** have an agreement.

Nutritional supplements

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

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

Infant Formulas

- Certain infant (birth through 12 months) formulas are covered when: There is a diagnosis as having multiple food protein intolerance and a **physician** has prescribed specialized, non-standard, formulas and
- There has not been a responsive result to trials of standard non-cow milk-based formulas including soybean and goat milk.

Infant pasteurized donated breast milk

Pasteurized donated breast milk which may include human milk fortifiers for infants under the age of six months is covered when:

- A **provider** prescribes the milk because the infant is medically or physically unable to receive maternal breast milk in sufficient quantities or breast feed despite optimal lactation support and the infant meets any of the following:
  - A body weight below health levels
  - The infant is at a high risk of developing necrotizing enterocolitis due to a congenital or acquired condition
  - The infant has a congenital or acquired condition that may benefit from the use of donor breast milk.
- The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America, or that is licensed by the Department of Health.

Orthotic and prosthetic devices

Eligible health services include the expenses for obtaining an orthotic or prosthetic device from a licensed orthotist or prosthetist or any certified pedorthist.

Orthotic device means:

- A brace or support

Prosthetic device means:

- Any artificial device that is not surgically implanted and is used to replace a missing limb, appendage or any other external human body part including devices such as:
  - Artificial limbs
  - Hands
  - Fingers
  - Feet
  - Toes

Coverage includes:

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

Osteoporosis

Eligible health services include the diagnosis, treatment and management of osteoporosis by a **physician**. The services include Food and Drug Administration approved technologies, including bone mass measurement.

Sickle cell anemia

Eligible health services include the medical expenses and **prescription** drugs for treatment of sickle cell anemia.

Vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

Outpatient prescription drugs

What you and your dependents need to know about your outpatient prescription drug plan

Read this section carefully so that you and your dependents know:

- How to access **network pharmacies**
- How to access **out-of-network pharmacies**
- **Eligible health services** under your and your dependent's plan
- What outpatient **prescription drugs** are covered?
- Other services
- How to get an emergency **prescription** filled
- Where the schedule of benefits fits in
- What **precertification** requirements apply?
- How do I request a medical exception?
- What your plan doesn't cover – some **eligible health service** exceptions
- How you share the cost of your and your dependent's outpatient **prescription drugs**

Some **prescription drug**s may not be covered or coverage may be limited. However, all FDA approved drugs are covered. This does not keep you and your dependents from getting **prescription drug**s that are not **covered benefits**. You or your dependents can still fill your or your dependent's **prescription**, but you have to pay for it yourself. For more information see the *Where your schedule of benefits fits in* section, and see the schedule of benefits.

A **pharmacy** may refuse to fill a **prescription** order or refill when in the professional judgment of the pharmacist the **prescription** should not be filled. Examples include but are not limited to concerns regarding drug interactions, opioids or the prescriber.

How to access network pharmacies

How do you and your dependents find a network pharmacy?

You and your dependents can find a **network pharmacy** in two ways:

- **Online:** By logging onto your Aetna secure member website at www.aetna.com.
- **By phone:** Call the toll-free Member Services number on your member ID card. During regular business hours, a Member Services representative can assist you or your dependents. Our automated telephone assistant can give you or your dependents this information 24 hours a day.

You or your dependents may go to any **network pharmacies**. **Pharmacies** include **network retail**, **mail order** and **specialty pharmacies**.

How to access out-of-network pharmacies

You and your dependents can directly access an **out-of-network pharmacy** to get covered outpatient **prescription drugs**. When you use an **out-of-network pharmacy**, you pay your **network copayment** or **coinsurance** then you pay any remaining **deductible** and then you pay your **out-of-network** coinsurance.

If you or your dependents use an **out-of-network pharmacy** to obtain outpatient **prescription drugs**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your **network** outpatient **prescription drug** cost share
- Paying your **out-of-network** outpatient **prescription drug deductible**
- Your **out-of-network coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims and getting **precertification** for services received outside of New Jersey.

You can get **eligible health services** under your plan that are provided by an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You must request access to the **out-of-network provider** in advance and we must agree. If we do not agree and you disagree with our decision, please see the *When you disagree – claim determination procedures/complaints and appeals* section. Contact Member Services at the toll-free number on your ID card for assistance.

Note:

- **Network** cost-sharing also applies to **out-of-network prescription drug** benefits before **out-of-network** cost-sharing.
- If an **out-of-network pharmacy's** retail price for a **prescription drug** is less than your total cost-sharing amount, you will not be required to pay any more than the retail drug price.

Eligible health services under this plan:
What does your outpatient prescription drug plan cover?

Any **pharmacy** service that meets these three requirements:

- They are listed in the *Eligible health services under your plan* section.
- They are not carved out in the *What your plan doesn't cover - some eligible health service exceptions* section.
- They are not beyond any limits in the schedule of benefits

Your plan benefits are covered when you and your dependents follow the plan's general rules:

- You and your dependents need a **prescription** from your and your dependents **prescriber.**
- Your and your dependent's drug needs to be **medically necessary** for your and your dependent's **illness** or **injury.** See the *Medical necessity and precertification* requirements section.
- You and your dependents need to show your ID card to the **pharmacy** when you and your dependents get a **prescription** filled.

Covered services are based on the drugs listed in the **drug guide**. We exclude **prescription** drugs not in the **drug guide** unless we approve a medical exception. If it is **medically necessary** for you to use a **prescription** drug that is not in this **drug guide**, you or your **provider** must request a medical exception. See the *Requesting a medical exception* section for more information.

Generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. Your out-of-pocket costs may be less if you and your dependents use a **generic prescription drug** when available.

Prescription drugs covered by this plan are subject to misuse, waste, and/or abuse utilization review by us, your and your dependent's **provider**, and/or your and your dependent's **network pharmacy**. The outcome of this review may include: limiting coverage of the applicable drug(s) to one prescribing **provider** and/or one network **pharmacy**, limiting the quantity, dosage, day supply, requiring a partial fill or denial of coverage. If you disagree with the review, refer to the *When you disagree—claim determination procedures/complaints and appeals* section.

What outpatient prescription drugs are covered

Your and your dependent's **prescriber** may give you and your dependents a **prescription** in different ways, including:

- Writing out a **prescription** that you and your dependents then take to a **network pharmacy.**
- Calling or e-mailing a **network pharmacy** to order the medication.
- Submitting your and your dependent's **prescription** electronically.

Once you and your dependents receive a **prescription** from your and your dependent's **prescriber**, you and your dependents may fill the **prescription** at a **network retail**, **mail order** or **specialty pharmacy.**

Retail pharmacy

Generally, **retail pharmacies** may be used for up to a 90 day supply of **prescription drugs**. You and your dependents should show your ID card to the **network pharmacy** every time you and your dependents get a **prescription** filled. The **network pharmacy** will submit your and your dependent's claim. You will pay any cost sharing directly to the **network pharmacy**.

If you and your dependents receive medications for chronic condition(s), refills may be able to be synchronized. Synching medications means fewer trips to the **pharmacy** for refills. Contact us for more information to see if you and your dependents qualify.

Mail order pharmacy

If you and your dependents choose, you may purchase outpatient **prescription drugs** and insulin through a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage.

Specialty pharmacy

Specialty prescription drugs often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Each **prescription** is limited to a maximum 90 day supply. You and your dependents can access the list of **specialty prescription drugs** by logging onto your Aetna secure member website at www.aetna.com or calling the number on the back of your ID card.

All **specialty prescription drug** fills including the initial fill must be filled at a network **specialty pharmacy** unless it is an urgent situation.

Other services

Preventive contraceptives

For females who are able to reproduce, your outpatient **prescription drug** plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included in the drug guide. You can access the list of contraceptive drugs by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.

We cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost share. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method at no cost share.

After an initial 3 month supply is dispensed, a 6 month supply of the same contraceptive is covered regardless of whether the initial **prescription** was covered under this plan. For specific cost sharing see your **schedule** of benefits *Outpatient **prescription drugs*** or *Family planning services - female contraceptives* section.

Important Note: You may qualify for a medical exception if your provider determines that the contraceptives covered standardly as preventive are not medically appropriate. Your **prescriber** may request a medical exception and submit the exception to us.

Diabetic supplies

Eligible health services include but are not limited to the following diabetic supplies upon **prescription** by a **prescriber**:

- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs
- Oral agents for controlling blood sugar.

See your medical plan benefits for coverage of blood glucose meters and insulin pumps.

Immunizations

Eligible health services include preventive immunizations as required by the ACA guidelines when administered at a **network pharmacy**. You can call the number on your ID card to find a participating **network pharmacy**. You should contact the **pharmacy** for vaccine availability, as not all **pharmacies** will stock all available vaccines.

Infertility drugs

Eligible health services include oral and injectable **prescription drugs** used primarily for the purpose of treating the underlying cause of **infertility**.

Off-label use

U.S. Food and Drug Administration (FDA) approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your and your dependents' condition(s). Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your and your dependent's condition(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information)
  - Thomson Micromedex DrugDex System (DrugDex)
  - Clinical Pharmacology (Gold Standard, Inc.) or
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium; or

- Use for your and your dependent's condition(s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your and your dependent's condition(s) is equal to the dosage for the same condition(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above, or
  - The dosage has been proven to be safe and effective for your and your dependent's condition(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Health care services related to off-label use of these drugs may be subject to **precertification** or other requirements or limitations.

Orally administered anti-cancer drugs, including chemotherapy drugs

Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

Preventive care drugs and supplements

Eligible health services include preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the ACA guidelines when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Risk reducing breast cancer prescription drugs

Eligible health services include **prescription drugs** used to treat people who are at:

- Increased risk for breast cancer, and
- Low risk for adverse medication side effects

Sexual dysfunction/enhancement

Eligible health services include **prescription drugs** for the treatment of sexual dysfunction/enhancement. For the most up-to-date information on dosing, call the toll-free number on your ID card.

Specialized, Non-Standard, Infant Formulas

Eligible health services include specialized non-standard infant formulas:

- When the infant's **physician** has diagnosed the infant as having multiple food protein intolerance and has prescribed this formula
- When the infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

Tobacco cessation prescription and over-the-counter drugs

Eligible health services include FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

How you and your dependents get an emergency or urgent care prescription filled

You and your dependents may not have access to a **network pharmacy** in an emergency or **urgent care** situation, or you and your dependents may be traveling outside of the plan's **service area.** If you and your dependents must fill a **prescription**, we will reimburse you as shown in the table below.

Type of pharmacy	Your cost share
Network pharmacy	▪ You pay the **copayment**.
Out-of-network pharmacy	▪ You pay the **pharmacy** directly for the cost of the **prescription**. If you and your dependents are traveling outside the state of New Jersey, then you fill out and send a **prescription drug** refund form to us, including all itemized **pharmacy** receipts. If you and your dependents are in the state of New Jersey, but outside the service area, the **pharmacy** will submit your and your dependents' claim to us ▪ Coverage is limited to items obtained in connection with covered emergency and out-of-area urgent care services. ▪ Submission of a claim doesn't guarantee payment. If your and your dependents' claim is approved, you and your dependents will be reimbursed the cost of your **prescription** less your **copayment/coinsurance.**

Where your schedule of benefits fits in

You are responsible for paying your part of the cost sharing. The schedule of benefits shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible for costs not covered under this plan.

Your and your dependents' **prescription drug** costs are based on:

- The type of **prescription** you and your dependents are prescribed
- Where you and your dependents fill your and your dependents' **prescription**

The plan may in certain circumstances make some **brand-name prescription drugs** available to members at the **generic prescription drug copayment** level.

How your copayment/coinsurance works

Your **copayment/coinsurance** is the amount you pay for each **prescription** fill or refill. Your schedule of benefits shows you which **copayments/coinsurance** you need to pay for specific **prescription** fill or refill. You will pay any cost sharing directly to the **network pharmacy**.

How your outpatient prescription drug maximum out-of-pocket limit works

You will pay your outpatient **prescription drug copayments/coinsurance** up to the outpatient **prescription drug maximum out-of-pocket limit** for your plan.

Your schedule of benefits shows the outpatient **prescription drug maximum out-of-pocket limits** that apply to your plan. Once you reach your outpatient **prescription drug maximum out-of-pocket limit**, your plan will pay for outpatient **prescription drug covered benefits** for the remainder of that Calendar Year.

What precertification requirements apply

Why do some drugs need precertification?

For certain drugs, you, your and your dependents' **prescriber** or your and your dependent's pharmacist needs to get approval from us before we will agree to cover the drug for you and your dependents. The requirement for getting approval in advance guides appropriate use of precertified drugs and makes sure they are **medically necessary**. For the most up-to-date information, call the toll-free number on your member ID card or log on to your Aetna secure member website at www.aetna.com.

Aetna will phone the **prescriber** within 24 hours of a request for a **precertification**. The request will be deemed approved if we do not respond within 24 hours of the request. The list of **prescription drugs** requiring **precertification** is subject to change by **Aetna**. An updated copy of the list of **prescription drugs** requiring **precertification** shall be available upon request by you and your dependents or may be accessed at www.aetna.com.

What happens if you and your dependents do not get precertification?

If you and your dependents do not get **precertification**, you must directly pay the **network pharmacy** in full for the cost of the **prescription drug**. To be reimbursed for this cost, you must submit a written request for reimbursement to us. You should include:

- a copy of the receipt for the payment of the **prescription drug**
- documentation from the **prescriber** indicating why you and your dependents need this prescription

Upon approval, **Aetna** will reimburse you for the full cost of the **prescription drug** minus any applicable **copaymen**t.

For the most up-to-date information, call the toll-free Member Services number on your member ID card or log on to your Aetna secure member website at www.aetna.com.

How do I request a medical exception

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not listed on the **drug guide** or for which health care services are denied through **precertification.** You and your dependents, someone who represents you or your dependents or your or your dependent's **prescriber** can contact us and will need to provide us with the required clinical documentation. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If approved by us, you will receive the **preferred drug** or **non-preferred drug** benefit level.

You and your dependents, someone who represents you or your dependents or your or your dependent's **prescriber** may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a **non-preferred drug**. You and your dependents, someone who represents you or your dependents or your or your dependents' **prescriber** may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716 M22
- Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **prescriber** of our decision. Refer to the *When you disagree-claim determination procedures/complaints and appeals* section in the **Certificate** for details of the appeal process.

Prescribing units

Some outpatient **prescription drugs** are subject to quantity limits. These quantity limits help your and your dependents' **prescriber** and pharmacist check that your and your dependent's outpatient **prescription drug** is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these quantity limits.

Any outpatient **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **copayments**.

What your plan doesn't cover – some eligible health service exceptions

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

In this section we tell you about the exceptions. We've grouped them to make it easier for you to find what you want.

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

Please look under both categories to make sure you understand what exceptions may apply in your and your dependent's situation.

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

General exceptions

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

Examples of these are:

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

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

Cosmetic services and plastic surgery

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

Coverage will be provided for

- Covered newborns from the moment of birth for the care and treatment of medically diagnosed congenital defects and birth abnormalities)
- Reconstructive breast surgery following mastectomy as explained in *Reconstructive surgery and supplies*

Cost share waived

- Any cost for a service when any **out-of-network provider** waives all or part of your **copayment**, **coinsurance**, **deductible**, or any other amount

Counseling

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

Court-ordered services and supplies

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

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed.
- Administering oral medications.
- Care of a stable tracheostomy (including intermittent suctioning).
- Care of a stable colostomy/ileostomy.
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
- Care of a bladder catheter (including emptying/changing containers and clamping tubing).
- Watching or protecting you or your dependents.
- Respite care, adult (or child) day care, or convalescent care.
- Institutional care. This includes **room and board** for rest cures, adult day care and convalescent care.
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods.
- Any other services that a person without medical or paramedical training could be trained to perform.
- Any service that can be performed by a person without any medical or paramedical training.

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

Dental services related to:

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

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts or preventive dental services for children.

Early intensive behavioral interventions

Examples of those services are:

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

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing.
- Special education, remedial education, wilderness treatment program, job training and job hardening programs

Examinations

Any health examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

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

Facility charges

For care, services or supplies provided in:

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

Foot care

(except diabetic footcare to minimize the risk of infection)

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as such as routine cutting of nails, when there is no **illness** or **injury** in the nails

Growth/height care

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

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible health services under your plan – Habilitation therapy service*s section.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device (except those items listed as included eligible health services under *Diabetic equipment, supplies and education*. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments

- Support hose
- Bandages
- Bedpans
- Syringes
- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Outpatient prescription or non-prescription drugs and medicines

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

Personal care, comfort or convenience items

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

Pregnancy charges

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

Routine exams

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

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

- Non-emergency services, outpatient **prescription drugs** or supplies received outside of the United States. They are not covered even if they are covered in the United States under this booklet-certificate.

Sexual dysfunction and enhancement

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

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for the purpose of enhancing your or your dependent's:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

Telemedicine and/or **telehealth**

- Services given by **providers** that are not contracted with **Aetna** as **telemedicine** and or **telehealth** and/or **providers**
- Services given when you are not present at the same time as the **provider**
- Services including:
  - Telephone calls
  - **Telemedicine** and/or **telehealth** kiosks
- The use, in isolation, of:
  - Audio-only telephone conversation
  - Electronic mail
  - Instant messaging
  - Phone text
  - Facsimile transmission

Therapies and tests

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

Tobacco cessation

- This includes:
  - Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
  - Hypnosis and other therapies, except as specifically provided in the *Substance use disorders treatment* section
  - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
  - Nicotine patches, except as specifically provided in the *Substance use disorders treatment* section
  - Gum, except as specifically provided in the *Substance use disorders treatment* section

Treatment in a federal, state, or governmental entity

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

Wilderness treatment programs

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

Work related illness or injuries

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

Additional exceptions for specific types of care

Preventive care and wellness

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

Health wellness promotion program

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

Family planning services

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

Physicians and other health professionals

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

Hospital and other facility care

Hospital Care

- A **stay** in the **hospital** that you or your dependents elect after your or your dependent's **provider** has advised you or your dependents no longer require inpatient confinement

Alternatives to facility stays

Outpatient surgery and physician surgical services

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

Home health care

- Services for infusion therapy
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation

- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Services that are needed on a full-time or 24 hour basis

Hospice care

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

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

Skilled nursing facility

- A **stay** in the **skilled nursing facility** that you or your dependents elect after your **provider** has advised you or your dependents no longer require inpatient confinement

Emergency services and urgent care

- **Non-emergency care** in a **hospital** emergency room facility
- Non-urgent care in an **urgent care facility**(at a non-hospital freestanding facility)

Specific conditions

Infertility treatment

- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- Any charges associated with:
  - Surrogacy for you or the surrogate where the surrogate is not covered under this plan. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation (freezing) of eggs, embryos, or sperm
  - Storage of eggs, embryos, or sperm
  - Thawing of cryopreserved (frozen) eggs, embryos or sperm
  - Nonmedical costs of an approved egg or sperm donor
  - Any medical or psychological prescreening of any prospective donors.
- Home ovulation prediction kits or home pregnancy tests
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- More than four completed egg retrievals while you are covered under this plan or any other plan with this policyholder
- Egg retrievals if you are over 45 years of age

Family planning services - other

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

Maternity and related newborn care

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

Mental health treatment

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

Substance use disorders treatment

- Except as provided in the *Eligible health services under your plan – Substance use disorders treatment* section substance use disorder rehabilitation treatment on an inpatient or outpatient basis

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Transplant services

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

Specific therapies and tests

Orally administered anti-cancer prescription drugs

- Those that are prescribed to maintain red or white cell counts
- Those that treat nausea
- Those prescribed to support the anti-cancer **prescription drugs**

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Specialty prescription drugs

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

Other services

Ambulance services

- Fixed wing air ambulance from an **out-of-network provider**
- Routine transportation to receive outpatient or inpatient services

Clinical trial therapies (experimental or investigational)

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

Clinical trial therapies (routine patient costs)

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

Durable medical equipment (DME)

Examples of these items are the purchase or rental of:

- Exercise cycles
- Water purifiers
- Hypo-allergenic pillows
- Mattresses or waterbeds
- Whirlpool or swimming pools
- Exercise and massage equipment
- Air conditioners
- Air purifiers
- Humidifiers
- Dehumidifiers
- Escalators
- Elevators
- Ramps
- Stair glides
- Emergency alert equipment
- Handrails
- Heat appliances
- Improvements made to a person's house or place of business
- Adjustments made to vehicles

Hearing aids and exams

The following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 24 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist
- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**
- Any tests, appliances and devices to:
  - Improve your or your dependent's hearing. This includes hearing aid batteries and auxiliary equipment.
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

Nutritional supplements

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

Orthotic devices

- Fabric and elastic supports
- Corsets
- Arch supports
- Trusses
- Elastic hose
- Canes
- Crutches
- Cervical collars
- Dental appliances or
- Other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities

except as covered in the *Eligible health services under your plan – Other services* section.

Prosthetic devices

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

except as covered in the *Eligible health services under your plan – Other services* section

Vision Care

Adult vision care

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Vision care services and supplies

Your plan does not cover vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section.

- Special supplies such as non-**prescription** sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your or your dependent's stay in a **hospital** or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Outpatient prescription drugs

Abortion drugs

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug

Biological sera

Cosmetic drugs

- Medications or preparations used for cosmetic purposes except those used to treat newborn congenital defects.

Compounded prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA)

- Including compounded bioidentical hormones

Devices, products and appliances, except those that are specially covered

Dietary supplements including medical foods

Drugs or medications

- Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- That includes the same active ingredient or a modified version of an active ingredient as a covered **prescription drug** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** including **biosimilars** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Aetna's** Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications.
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies

Duplicative drug therapy (e.g. two antihistamine drugs)

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunizations related to travel or work

Immunization or immunological agents except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section.

Implantable drugs and associated devices except as specifically provided in the *Eligible health services under your plan –Outpatient prescription drugs* section.

Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us
- Needles and syringes, except for those used for self-administration of an injectable drug
- Any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.

Prescription drugs:

- Dispensed by other than a **network retail**, **mail order** and **specialty pharmacies** except as specifically provided in the *What prescription drugs are covered* section.
- Dispensed by a **mail order pharmacy** that is an **out-of-network pharmacy**, except in a medical emergency or urgent care situation except as specifically provided in the *How to get an emergency prescription filled* section.
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this provision.
- Dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is not clinically superior to that drug as determined by the plan.
- Generally, non-preferred drugs are not chosen by your prescriber. They have a higher cost sharing for you. However, there are times when **non-preferred drugs**, are specifically prescribed as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

Refills

- Refills dispensed more than one year from the date the latest **prescription** order was written.

Replacement of lost or stolen prescriptions

Smoking cessation

- Smoking cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)

Test agents, except diabetic test agents

We reserve the right to exclude:

- A manufacturer's product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the **preferred drug guide**.
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our **preferred drug guide**.

Who provides the care

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

Network providers

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

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section.
- Urgent care – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section.
- Transplants – see the description of transplant services in the *Eligible health services under your plan - specific conditions* section

You and your dependents may select a **network provider** from the **directory** through your Aetna secure member website at www.aetna.com. You can search our online **directory** for names and locations of **providers**.

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

Your PCP

We encourage you and your dependents to access **eligible health services** through a **PCP**. They will provide you and your dependents with primary care.

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

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

How do you choose your PCP?

You and your dependents can choose a **PCP** from the list of **PCPs** in our **directory**. See the *Who provides the care, Network providers* section.

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

What will your and your dependents' PCP do for you and your dependents?

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

Your and your dependent's **PCP** can also:

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

How do I change my or my dependent's PCP?

You and your dependent's may change your **PCP** at any time. You and your dependents can call us at the toll-free number on your ID card or log on to your Aetna secure member website at www.aetna.com to make a change. The change will become effective:

- Upon our receipt and approval of the request, but no later than 14 days after the receipt of the request
- Immediately if the change of the **PCP** is because of the termination of the **PCP** from the network.

Our national infertility unit

Our national **infertility** unit is here to help you and your dependents. It is staffed by a dedicated team of registered nurses and **infertility** coordinators with expertise in all areas of **infertility** who can help:

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

Out-of-network providers

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

- Paying your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims and getting **precertification** for services received outside of New Jersey

You can get **eligible health services** under your plan that are provided by an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You must request access to the **out-of-network provider** in advance and we must agree. If we do not agree and you disagree with our decision, please see the *When you disagree – claim determination procedures/complaints and* appeals section. Contact Member Services at the toll-free number on your ID card for assistance.

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

You and your dependents may have to find a new **provider** when:

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

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

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

If your and your dependents' **PCP** or another **provider** who is treating you and your dependents leaves our network, we will give you and your dependents 30 business days advance notice. However, we may waive the 30 day prior notice if the **provider** is being terminated immediately due to:

- Breach of contract
- Fraud
- Our medical director is of the opinion the **provider** is an imminent danger to you and your dependents or the public health, safety or welfare

Existing covered persons

If a **network provider**

- Either voluntarily or involuntarily stops participation in our **provider** network plan as a **network provider** or
- Stops participation with us as a **network provider** for reasons other than
  - Imminent harm to patient care
  - Fraud
  - Final disciplinary action by a state licensing board that impairs the **network provider's** ability to practice

We will allow you and your dependents to continue coverage for an ongoing course of treatment with your and your dependents' current **network provider** during a transitional period.

Coverage continues for up to four months from the date of notice (transitional period) to you and your dependents that:

- The **network provider** is no longer a **network provider**
- The **network provider** stopped participation with Us

Reimbursement will be at the **network provider** cost sharing during the transitional period.

The notice will include specific instructions on how to request continuation of care during the transitional period.

Condition or services	**Duration of transitional period**
Pregnancy	Postpartum plus up to six weeks after delivery
Post-operative follow up care	Duration of the treatment or up to 6 months, whichever occurs first.
Oncological treatment	Duration of the treatment or up to 12 months, whichever occurs first.
Mental Health treatment	Duration of the treatment or up to 12 months, whichever occurs first.

If you and your dependents are receiving the above services in an acute care facility, we shall continue to provide coverage for services rendered by the health care professional regardless of whether the acute care facility is under contract or agreement with **Aetna**.

The coverage will be authorized by us for the transitional period only if the **hospital** or **provider** agrees to accept reimbursement by us at the **negotiated charge** and/ or cost-sharing established by us in effect prior to the start of a transitional period as payment in full.

If you and your dependents are admitted to a health care facility on the date the contract is terminated, we shall continue to provide benefits for you and your dependents until the date you and your dependents are discharged from the facility or exhaustion of your benefits under the contract, whichever occurs first.

If a **network provider** stops participation in our **provider** network plan because of:

- Breach of contract
- Fraud
- Our medical director is of the opinion the **provider** is an imminent danger to you and your dependents or the public health, safety or welfare

we will not continue services. If you and your dependents disagree with this, you and your dependents should follow the procedures in the *When you disagree- claim determination procedures/complaints and appeals* section. **Aetna** shall not be liable for any inappropriate treatment provided to you and your dependents by a **provider** who is no longer under contract with us.

If we refer you and your dependents to a **network provider**, the service or supply shall be covered as an **out of network** service or supply. We are fully responsible for payment to the **provider** and you and your dependents will only need to pay any applicable **out of network copayment** or **coinsurance** for the service or supply.

This provision shall not require us to provide coverage for benefits otherwise not covered under this certificate.

What the plan pays and what you pay

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

- Your and your dependent's **deductible**
- Your and your dependent's **copayments/coinsurance**
- Your and your dependent's **maximum out-of-pocket limit**

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you and your dependents get care that is not an **eligible health service**.

The general rule

When you and your dependents get **eligible health services**:

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

  And then

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

  And then

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

When we say "expense" in this general rule, we mean the **negotiated charge** for a **network provider,** and the **recognized charge** for an **out-of-network provider**. See the *Glossary* section for what these terms mean.

Important exception – when your plan pays all

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

Important exceptions – when you pay all

You pay the entire expense for a **health service**:

- When you and your dependents get a health care service or supply that is not **medically necessary.** See the *Medical necessity, and precertification requirements* section.

- When your plan requires **precertification**, you and your dependents **physician** requested it, we refused it, and you and your dependents get an **eligible health service** without **precertification**. You may be subject to a penalty or you may be required to pay a higher cost share. See the *Medical necessity, and precertification requirements* section.

- When you get an **eligible health service** from an **out-of-network provider** and the **provider** waives all or part of your cost share.

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

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments including any charges incurred

Neither you nor we are responsible for:

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

Where your schedule of benefits fits in

How your and your dependents' deductible works

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

How your and your dependents' copayment/ coinsurance works

Your and your dependents' **copayment/coinsurance** is the amount you pay for **eligible health services** after you have paid your and your dependents' **deductible**. Your schedule of benefits shows you which **copayments/coinsurance** you need to pay for specific **eligible health services**.

You will pay the **physician, PCP copayment/coinsurance** when you and your dependents receive **eligible health services** from any **PCP**.

How your and your dependents' maximum out-of-pocket limit works

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

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

When you disagree - claim determination procedures/complaints and appeals

In the previous section, we explained how you and we share responsibility for paying for your **eligible health services**.

When a claim comes in, we decide and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

Your and your dependents' **provider** will send us a claim on your and your dependents' behalf. Your and your dependents' **provider** located in New Jersey will send us a claim on your and your dependents' behalf. And we will review that claim for payment to the **provider**.

For claims involving **out-of-network providers** located outside of New Jersey**:**

Notice	**Requirement**	**Deadline**
Submit a claim	• You should notify and request a claim form from the policyholder. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send us notice and proof as soon as reasonably possible. • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges – Any medical documentation you received from your provider.
Proof of loss (claim)	• A completed claim form and any additional information required by us.	• You must send us notice and proof as soon as reasonably possible.
Benefit payment	• Written proof must be provided for all benefits. • If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim

An urgent claim is one for which the doctor treating you decides delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them.

Post-service claim

A post service claim is a claim that involves health care services you have already received.

Concurrent care claim extension

A concurrent care claim extension occurs when you ask us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as **copayments/coinsurance** and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

Claim determination procedures

A claim occurs whenever you or your authorized representative, such as a **provider**, requests:

- **Precertification** as required by the plan from us
- A **referral** as required by the plan from a **provider**
- Payment for services or treatment received

Most claims do not require forms to be submitted as they are sent directly from the **provider** to us. However, if you receive a bill, the bill must be submitted promptly to us for claim determination and payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on the Member ID card.

We will make a decision on your claim**.** For **urgent care claims** and **pre-service claims**, we will send you written notification of the determination, whether adverse or not adverse**.** For other types of claims, you may only receive notice if **Aetna** makes an **adverse benefit determination.** In the case of a **concurrent care** claim, written notification will go to your **provider.**

All **adverse benefit determinations** related to **utilization review** will be decided by a **physician**.

The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

We may need to tell your **physician** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital.**

Aetna's timeframe for responding to utilization review claims				
Type of notice	**Urgent care claim**	**Pre-service claim**	**Post-service claim**	**Concurrent care claim**
Initial determination (us)	72 hours	15 days	30 days	24 hours for urgent request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (us)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

*We have to receive the request at least 24 hours before the previously approved health care services end.

Aetna's timeframe for responding to non-utilization review claims	
Type of notice	**Post-service claim**
Initial determination (us)	30 calendar days
Extensions	15 calendar days
Additional information request (us)	30 calendar days
Response to additional information request (you)	30 calendar days

If coverage is rescinded:

- We will provide you with a 30 day advance written notice prior to the date of the rescission
- Refund any premiums paid for any period after the termination date, minus the cost of covered services provided to during this period

The date of the rescission will be the date coverage would have otherwise terminated if a complaint had not been filed

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized amount** with an **out-of-network provider**, except for your and your dependents' share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if we rescind your and your dependents' coverage entirely. An adverse decision may be for one or more of the following reasons:

- **Utilization Review (UR)**. Includes decisions regarding:
  - **Experimental or investigational** procedures
  - Medical necessity
  - Appropriateness
  - Health care setting
  - Level of care
  - Effectiveness of a **covered benefit**.

- **No coverage.** We determine that a service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of **covered benefits**.
- **Exclusion** A service or supply is excluded from coverage.
- **Limitation.** A **plan** limitation has been reached.
- **Eligibility**. We determine you or your dependents are not eligible to be covered by **Aetna.**
- **Experimental or investigational.** A decision that the service or supply is an **experimental or investigational** procedure.
- **Medically necessary**. A decision that the service or supply is not **medically necessary**.
- **Rescission**. Termination of coverage back to the original effective date.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call the toll-free number on your ID card. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint**.** We will let you know if we need more information to make a decision.

An appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us calling the toll-free number on your ID card.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling the toll-free number on your ID card. You need to include:

- Your name
- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by calling the toll-free number on your ID card. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. The first appeal may be verbal or in writing. A verbal appeal can be made by calling the number on your ID card. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision. A second appeal must be in writing.

Important note:

If you want to appeal an adverse benefit decision regarding a **substance use disorders** treatment claim, go to the *Appeals of inpatient substance use disorders treatment claims* section.

Urgent care or pre-service claim appeals

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding appeals

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. When the **appeal** is for an **adverse decision** based on a **provider's** judgment, we will conduct different types of reviews depending on the level of the appeal:

Level one	**Level two**
The review will be conducted by a **physician** who was *not* the original reviewer nor a subordinate of the original reviewer who made the initial **adverse benefit determination**	A same or similar specialty review before a panel of **physicians** and/or other health care professionals who have not been involved in the utilization management determination at issue.

A level two appeal may have an informal hearing. Your **provider** or other experts may testify. You and an authorized representative may attend the level two **appeal** and question our representatives and present your case. We also have the right to present witnesses.

The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

Aetna's timeframe for responding to an appeal for utilization review claims		
Type of claim	**Level one appeal** **Response time from receipt of appeal**	**Level two appeal** **Response time from receipt of appeal**
Urgent care claim	Within 36 hours Review provided by our personnel not involved in making the **adverse benefit determination.**	Within 36 hours Review provided by our personnel not involved in making the **adverse benefit determination** and our Appeals Committee.
Pre-service claim	Within 10 calendar days Review provided by our personnel not involved in making the **adverse benefit determination.**	Within 15 calendar days Review provided by our personnel not involved in making the **adverse benefit determination** and our Appeals Committee.
Concurrent care claim extension	Treated like an **urgent care claim** or a **pre-service claim** depending on the circumstances	Treated like an **urgent care claim** or a **pre-service claim** depending on the circumstances

Post-service claim	Within 20 calendar days Review provided by our personnel not involved in making the **Adverse Benefit Determination**.	Within 20 business days Review provided by our personnel not involved in making the **Adverse Benefit Determination** and our Appeals Committee.
Aetna's timeframe for responding to an appeal for non-utilization review claims		
Type of benefit determination	**Level one appeal Response time from receipt of appeal**	**Level two appeal Response time from receipt of appeal**
Rescission of coverage	Within 30 calendar days	Within 30 calendar days
Post-service claim	Within 30 calendar days	Within 30 calendar days

Appeals of inpatient substance use disorders treatment claims

Aetna will notify you, an authorized representative and your **physician** of an inpatient care **substance use disorders** treatment claim decision within 24 hours. This notice will include your rights with regard to filing an expedited internal **appeal** of an **adverse determination**. Aetna will communicate the determination regarding your **appeal** of the **adverse determination** within 24 hours to you, an authorized representative and your **physician**.

If the determination is to uphold the denial, you, an authorized representative or your physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program through the Department of Banking and Insurance. An independent utilization review organization shall make a determination within 24 hours.

If the independent utilization review organization upholds the determination and it is determined continued inpatient care is not **medically necessary**, **Aetna** shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and you shall only be responsible for any applicable **copayment, deductible** and **coinsurance** for the **stay** through that date as applicable under the contract. For any costs incurred after the day following the date of determination until the day of discharge, you shall only be responsible for any applicable cost sharing, and any additional charges shall be paid by the **facility** or **provider.**

Exhaustion of appeal process

You may contact the New Jersey Department of Banking and Insurance to file a **complaint/appeal** or, request an investigation of a **complaint/appeal** at any time. You are not required to exhaust the level one and level two **appeals** process before contacting the New Jersey Department of Banking and Insurance.

New Jersey Department of Banking and Insurance
Office of Managed Care
Consumer Protection Services
P.O. Box 329
Trenton, New Jersey 08625-0329

Before filing a level one or two **appeal** with **Aetna**, you or your authorized representative may also contact the New Jersey Office of Insurance Claims Ombudsman if you are dissatisfied with the decision reached by **Aetna.**

Office of Insurance Claims Ombudsman
Department of Banking and Insurance
P.O. Box 472
Trenton, NJ 08625-0472
Phone: 800-446-7467
(outside of NJ call 609-292-5316 and ask for the Ombudsman's Office)
Fax: 609-292-2431
Email: ombudsman@dobi.state.nj.us

In most situations you must complete the two levels of appeal with us before you can take these other actions:

- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the two levels of appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- We did not follow all of the claim determination and appeal requirements of the New Jersey Department of Banking and Insurance. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and us.

External review

External review is a review done by people in an organization outside of **Aetna**. This is called an Independent Utilization Review Organization (IURO). An IURO is assigned by the State Insurance Commissioner and is made up of **physicians** or other appropriate **providers**. The IURO must have expertise in the problem or question involved.

You have a right to external review only if:

- Our claim decision involved medical judgment.
- We decided the service or supply is not **medically necessary** or not appropriate.
- We decided the service or supply is **experimental or investigational**.
- You have received an adverse determination.

There are times when you do not have to complete the level one and level two **appeal** processes. You may pursue an a**ppeal** directly through the Independent Health Care Appeals program if:

- A determination on any **appeal** regarding **urgent** or **emergency care** is not given to you within 72 hours of receipt by us
- A determination on an initial **appeal**, is not given to you within 10 calendar days of the date we received notice
- A determination of a subsequent level of **appeal** is not given to you within 20 business days of the date we received notice

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To: New Jersey Department of Banking and Insurance
  Office of Managed Care
  Consumer Protection Services
  P.O. Box 329
  Trenton, New Jersey 08625-0329
- Within 4 months of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

The fee for filing an **external review** is $25.00, payable by check or money order to the New Jersey Department of Banking and Insurance. The filing fee shall be refunded if the final determination is reversed by the IURO. Upon a determination of financial hardship, the fee may be reduced to $2.00. Financial hardship may be demonstrated by you through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ FamilyCare, General Assistance, SSI, or New Jersey Unemployment Assistance. Annual filing fees for any one **covered person** shall not exceed $75.00.

The New Jersey Department of Banking and Insurance will:

- Contact the IURO that will conduct the review of your claim who will.
  - Consider appropriate credible information that you sent.
  - Follow our contractual documents and your plan of benefits.

How long will it take to get a preliminary IURO decision?
We will tell you of the IURO decision not more than 45 business days after we receive your Request for External Review form with all the information you need to send in. The IURO will also advise if additional information is needed. If so, the IURO will review new information within one business day of receipt. When the IURO determines there is a reason to conduct a full review this means the file has been accepted for a final IURO decision.

How long will it take to get a final IURO decision?
The IURO shall conduct a full review to determine whether, as a result of **Aetna's** utilization management determination, you were deprived of **medically necessary covered benefits**. The IURO shall review:

- All pertinent medical records
- Consulting **physician** reports
- Other documents submitted by the parties
- Any applicable, generally accepted practice guidelines developed by:
  - The Federal government
  - National or professional medical societies
  - Boards and associations
- Any applicable clinical protocols
- Practice guidelines developed by us

An expert **physician** in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the **external review** will conduct the review. All final decisions of the IURO shall be approved by the medical director of the IURO who shall be a **physician** licensed to practice in New Jersey.

The IURO shall complete its review and issue its decision as soon as possible which, in no event shall exceed 45 calendar days from receipt of the request for the IURO review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO shall, prior to the conclusion of the preliminary review, provide written notice to you and your dependents, to the New Jersey Department of Banking and Insurance, and to **Aetna** setting forth the status of its review and the specific reasons for the delay.

But sometimes you can get a faster external review decision. Your **provider** must call us or send us a Request for External Review form.

There are two scenarios when you may be able to get a faster external review:
Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment)
- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment), or
- The adverse determination concerns an admission, availability of care, continued stay or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 48 hours of us getting your request.

We will stand by the decision of the IURO unless we can show conflict of interest, bias or fraud. We will provide claim payments immediately even if we want to seek legal review of the IURO's decision. Within 10 days of receipt of the decision, we must send a copy of our plan to implement the IURO's decision to you, the IURO and the New Jersey Department of Banking and Insurance. If we request a legal review of the IURO's decision, we will pay the cost.

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Coordination of benefits

A person may be covered for health benefits or services by more than one plan. If this happens, we will coordinate what we pay or provide with what another plan pays or provides. This is called coordination of benefits (COB).

In this section, we explain how we determine which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits. It is also intended to preserve you and your dependents rights to coverage under all plans under which you and your dependents are covered.

Key terms

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

Allowable expense means:

- The charge for any health care service, supply or other expense for you are responsible when the health care service, supply or other expense is covered at least in part by any of the plans involved, except where a law requires another definition, or as stated below.

  When this plan is coordinating benefits with a plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, allowable expense is limited to items covered under the other plan.

  We will not consider the difference between the cost of a private **hospital** room and that of a semi-private **hospital** room as an allowable expense unless the stay in a private room is **medically necessary** and appropriate.

  When this plan is coordinating benefits with a plan that limits coordination of benefits to a specific coverage, we will only consider corresponding services, supplies or other expense which the other plan considers an allowable expense.

Claim determination period means:

- A calendar year, or any part of a calendar year, during which you and your dependents are covered by this plan and at least one other plan and incurs allowable expense(s) under these plans.

Plan means:

- Coverage with which coordination of benefits is allowed. Plan includes:
  - Group insurance and group subscriber contracts, including insurance continued according to a federal or state continuation law
  - Self-funded arrangements of group or group-type coverage, including insurance continued according to a federal or state continuation law
  - Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued according to a federal or state continuation law
  - Group hospital indemnity benefit amounts that exceed $150.00 per day
  - Medicare or other governmental benefits, except when, according to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan

- Plan does not include:
  - Individual or family insurance contracts or subscriber contracts
  - Individual or family coverage through a health maintenance organization (HMO) or under any other prepayment, group practice and individual practice plans
  - Group or group-type coverage where the cost of coverage is paid solely by the covered person coverage being continued according to a federal or state continuation law will be considered a plan
  - Group hospital indemnity benefit amounts of $150.00 per day or less
  - School accident-type coverage
  - A state plan under Medicaid

Primary plan means:

- A plan whose benefits for your health care coverage must be determined without taking into consideration the existence of any other plan. There may be more than one primary plan. A plan will be the primary plan if either of the below exist:
  - The plan has no order of benefit determination rules, or it has rules that differ from those contained in this coordination of benefits section, or
  - All plans which cover you use order of benefit determination rules consistent with those contained in the coordination of benefits section and under those rules, the plan determines its benefits first.

Reasonable and Customary means:

- An amount that is not more than the usual or customary charge for the service or supply as determined by us, based on a standard which is most often charged for a given service by a **provider** within the same geographic area.

Secondary plan means:

- A plan which is not a primary plan. If you are covered by more than one secondary plan, the order of benefit determination rules of this coordination of benefits section will be used to determine the order in which the benefits payable under the multiple secondary plans are paid. The benefits of each secondary plan may consider:
  - The benefits of the primary plan(s) and
  - The benefits of any other plan which, under this coordination of benefits section, has its benefits determined before those of that secondary plan.

Here's how COB works

- We consider each plan separately when coordinating payments. The primary plan pays or provides services or supplies first, as though the secondary plan doesn't exit. If a plan has no COB provision, or if the order of benefit determination rules differ from those in this section, it is the primary plan. A secondary plan takes into consideration the benefits provided by a primary plan when, according to the rules below, the plan is the secondary plan. If there is more than one secondary plan, the order of benefit determination rules determine the order among the secondary plans. During each claim determination period the secondary plan(s) will pay up to the remaining unpaid allowable expenses, but no secondary plan will pay more than it would have paid if it had been the primary plan. The method the secondary plan uses to determine the amount to pay is outlined below in the *Determining who pays* section.

  The secondary plan will not reduce allowable expenses for **medically necessary** and appropriate services or supplies on the basis that **precertification**, preapproval, notification or second surgical opinion procedures were not followed.

Determining who pays under a health plan

The benefits of the plan that covers you as an employee, member, subscriber or retiree will be determined before those of the plan that covers you as a dependent. The coverage as an employee, member, subscriber or retiree is the primary plan.

The benefits of the plan that covers you as an employee who is neither laid off nor retired, or as a dependent of such person, will be determined before those for the plan that covers you as a laid off or retired employee, or as such a person's dependent. If the other plan does not contain this rule, and as a result, the plans do not agree on the order of benefit determination, this portion of this provision is ignored.

The benefits of the plan that covers you as an employee, member, subscriber or retiree, or dependent of such person, will be determined before those of the plan that covers the person under a federal or state continuation law. If the other plan does not contain this rule, and as a result, the plans do not agree on the order of benefit determination, this portion of this provision is ignored.

If a child is covered as a dependent under plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- The benefits of the plan of the parent whose birthday falls earlier in the calendar year will be determined before those of the parent whose birthday falls later in the calendar year.
- If both parents have the same birthday, the benefits of the plan which covered the parent for a longer period of time will be determined before those of the plan which covered the other parent for a shorter period of time.
- Birthday refers only to month and day in a calendar year, not the year in which the parent was born.
- If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule is ignored.

If a child is covered as a dependent under plans through both parents, and the parents are separated or divorced, the following rules apply:

- The benefits of the plan of the parent with custody of the child will be determined first.
- The benefits of the plan of the spouse of the parent with custody will be determined second.
- The benefits of the plan of the parent without custody will be determined last.
- If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that plan has actual knowledge of the terms of the court decree, then the benefits of that plan will be determined first. The benefits of the plan of the other parent will be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision is ignored.

If a child is covered as a dependent under plans through an individual who is not a parent such as a stepparent or grandparent, the individual will be treated as a parent for purposes of the order of benefits determination.

If the above order of benefits does not establish which plan is the primary plan, the benefits of the plan that covers the employee, member or subscriber for a longer period of time will be determined before the benefits of the plan(s) that covered the person for a shorter period of time.

How are benefits paid?

In order to determine which procedure to follow it is necessary to consider:

- How the primary plan and the secondary plan pay benefits
- Whether the **provider** who provides or arranges the services and supplies is in the network of either the primary plan or the secondary plan.

Benefits may be based on the reasonable and customary charge (R & C), or some similar term. This means that the **provider** bills a charge and you may be responsible for the full amount of the billed charge. In this section, a plan that bases benefits on a reasonable and customary charge is called an R & C plan.

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a **provider**, called a **network provider**, bills a charge, you may be responsible only for an amount up to the negotiated fee. In this section, a plan that bases benefits on a negotiated fee schedule is called a fee schedule plan. If you use the services of a non-network **provider**, the plan will be treated as an R & C plan even though the plan under which you are covered allows for a fee schedule.

Payment to the **provider** may be based on a capitation. This means that the HMO or other plan pays the **provider** a fixed amount per covered person. You are responsible only for the applicable **deductible**, **coinsurance** or **copayment**. If you use the services of a non-network **provider**, the HMO or other plan will only pay benefits in the event of **emergency services** or urgent care. In this section, a plan that pays **providers** based upon capitation is called a capitation plan. In the rules below, **provider** refers to the **provider** who provides or arranges the services or supplies and HMO refers to a health maintenance organization plan.

A plan determined to be a secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. Where a benefit is payable by both the primary and secondary plans on the basis of usual, customary and reasonable fees (UCR), the secondary plan will pay the difference between billed charges for allowable expenses and the amount paid by the primary plan as long as the amount is no greater than the amount the secondary plan would have paid if primary. The amount by which the secondary plan's benefits have been reduced will be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by you. As each claim is submitted, the secondary plan will determine its obligation to pay for allowable expenses based on all claims which were submitted up to that time during the claim determination period.

The benefits of the secondary plan will be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision, and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In this case, the benefits of the secondary plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.
When the benefits of this plan are reduced as described above, each benefit will be reduced in proportion, and the amount paid will then be charged against any applicable benefit limit of this plan.

Primary plan is R & C plan and secondary plan is R & C plan
The secondary plan will pay the lesser of:

- The difference between the amount of the billed charges and the amount paid by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

When the benefits of the secondary plan are reduced as a result of this calculation, each benefit will be reduced in proportion, and the amount paid will be charged against any applicable benefit limit of the plan.

Primary plan is fee schedule plan and Secondary plan is fee schedule plan
If the **provider** is a **network provider** in both the primary plan and the secondary plan, the allowable expense will be the fee schedule of the primary plan. The secondary plan will pay the lesser of:

- The amount of any **deductible**, **coinsurance** or **copayment** required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

The total amount the **provider** receives from the primary plan, the secondary plan and you will not exceed the fee schedule of the primary plan. In no event will you be responsible for any payment in excess of the **copayment**, **coinsurance** or **deductible** of the secondary plan.

Primary plan is R & C plan and secondary plan is fee schedule plan
If the **provider** is a **network provider** in the secondary plan, the secondary plan will pay the lesser of:

- The difference between the amount of the billed charges for the allowable expenses and the amount paid by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

You will only be responsible for the **copayment**, **deductible** or **coinsurance** under the secondary plan if you have no responsibility for **copayment**, **deductible** or **coinsurance** under the primary plan and the total payments by both the primary and secondary plans are less than the **provider's** billed charges. In no event will you be responsible for any payment in excess of the **copayment**, **coinsurance** or **deductible** of the secondary plan.

Primary plan is fee schedule plan and secondary plan is R & C plan
If the **provider** is a **network provider** in the primary plan, the allowable expense considered by the secondary plan will be the fee schedule of the primary plan. The secondary plan will pay the lesser of:

- The amount of any **deductible**, **coinsurance** or **copayment** required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

Primary plan is fee schedule plan and secondary plan is R & C plan or fee schedule plan
If the primary plan is an HMO plan that does not allow for the use of non-network **providers** except in the event of urgent care or **emergency services** and the service or supply you receive from a non-network **provider** is not considered as urgent care or **emergency services**, the secondary plan will pay benefits as if it were the primary plan.

Primary plan is capitation plan or fee schedule plan or R&C plan and secondary plan is capitation plan
If you receive services or supplies from a **provider** who is in the network of the secondary plan, the secondary plan will be responsible to pay the capitation to the **provider** and will not be responsible to pay the **deductible**, **coinsurance** or **copayment** imposed by the primary plan. You will not be responsible to pay any **deductible**, **coinsurance** or **copayments** of either the primary plan or the secondary plan.

Primary plan is an HMO and secondary plan is an HMO
If the primary plan is an HMO plan that does not allow for the use of non-network **providers** except in the event of urgent care or **emergency services** and the service or supply you receive from a non-network **provider** is not considered as urgent care or **emergency services**, but the **provider** is in the network of the secondary plan, the secondary plan will pay benefits as if it were the secondary plan, except that the primary plan will pay out-of-network services, if any, authorized by the primary plan.

How COB works with Medicare

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

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

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

- Age, disability, or
- End stage renal disease

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

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

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

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan
A disability other than ESRD and your employer has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is primary	We calculate our benefit as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expense.

Charges that satisfy your Part B deductible will be applied in the order received. We will apply the largest charge first when two or more charges are received at the same time.

How this plan works with automobile plans for automobile related injuries

This section explains how the benefits under this plan interact with benefits available when expenses are incurred as a result of an automobile related i**njury**.

Key terms

Automobile related i**njury** means:

- Bodily **injury** sustained by a person as a result of an accident:
  - while occupying, entering, leaving or using an automobile; or
  - as a pedestrian

  caused by an automobile or by an object propelled by or from an automobile.

Allowable expense(s) means:

- A **medically necessary**, reasonable and customary item of expense covered at least in part as an eligible expense by:
  - The policy
  - PIP, or
  - OSAIC

Eligible expense means:

- That portion of medical expense incurred for treatment of an **injury** which is covered under this plan without application of cash **deductibles** and **copayments**, if any or **coinsurance**.

Out-of-State Automobile Insurance Coverage (OSAIC) means:

- Any coverage for medical expenses under an automobile insurance policy other than PIP.

OSAIC includes automobile insurance policies issued in another state or jurisdiction.

PIP means:

- Personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determining who pays when there is an automobile plan for automobile related injuries

This plan provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for you under this plan. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insured's under another automobile policy. This plan may be primary for one covered person, but not for another if the person has separate automobile policies and has made different selections regarding primacy of health coverage.

This plan is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to this plan. In that case this plan will be primary.

If there is a dispute as to which plan is primary, this plan will pay benefits as if it were primary.

If this plan is primary to PIP or OSAIC, it will pay benefits for **eligible health services** in accordance with its terms.

The rules of the coordination of benefits section of this plan will apply if:

- You are insured under more than one insurance plan, and
- Such insurance plans are primary to automobile insurance coverage

If this plan is secondary to PIP or OSAIC, the actual benefits payable will be the lesser of:

- The allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying cash deductibles and copayments, or
- The benefits that would have been paid if this plan had been primary.

If this plan supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

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

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

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

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

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

We will not seek reimbursement for an overpayment, except in the case of fraud or a pattern of inappropriate billing or claims later than 18 months after the date of the first payment on the claim.
We will not seek more than one reimbursement for overpayment of a particular claim.

We will not seek reimbursement for an overpayment from a **Provider** on or before the 45th calendar day following our request for reimbursement.

Recovery rights related to workers' compensation

If medical benefits are provided to you and your dependents by **Aetna** and workers' compensation for the same **illness** or **injuries**, we have the right to recover those benefits as described below.

Workers' compensation benefits includes benefits paid in connection with a workers' compensation claim, whether:

- Paid by an employer directly
- A workers' compensation insurance carrier
- Any fund designed to compensate for workers' compensation claims

Aetna may exercise its recovery rights if the Deputy Directors or Referees of the Workers' Compensation Board incorporate into any:

- Award
- Order
- Approval of settlement

an order requiring the employer or the insurance carrier to reimburse us the amount of medical benefits paid by us.

The recovery rights will be applied even if we do not intervene in the action.

By accepting benefits under this plan, you and your dependents or your and your dependent's representatives agree to notify us of any workers' compensation claim made, and to cooperate with the process as described above.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you and your dependents may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued.
- You voluntarily stop your coverage.
- The group policy ends.
- You are no longer eligible for coverage, including when you move out of the service area.
- Your employment ends.
- We end your coverage.
- You become covered under an alternative plan offered by your employer.

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of **illness, injury**, sabbatical or other authorized leave as agreed to by the policyholder and us.	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue, until stopped by the policyholder, but not beyond 3 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage will stop on the date that your employment ends.
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section.
Your employment ends because of a paid or unpaid medical leave of absence	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 3 months from the start of the absence.

Your employment ends because of a leave of absence that is not a medical leave of absence	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 1 month from the start of the absence.
Your employment ends because of a military leave of absence.	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence.

It is your policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and the policyholder agree in writing to extend them.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage.
- You do not make the required contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above (other than:
  - Exhaustion of your overall maximum benefit
  - If you enroll under a group Medicare + Choice plan that we offer. However, dependent's coverage will end if your coverage ends under the Medicare + Choice plan
- Your dependent has exhausted his or her maximum benefit under your medical plan.

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners.
- The date the domestic partnership ends.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we end you and your dependents' coverage?

When we give notice of termination, the notice will advise you of your right to appeal according to the *When you disagree-claim determination procedures/complaints and appeals* section.

We will give you 31 days advance written notice if we end your coverage because:

- You do not cooperate or give facts that we need to administer the *COB* provisions.

We may immediately end your coverage if:

- You commit fraud or misrepresent yourself when you applied for or obtained coverage including misuse of a Member ID card. You can refer to the *A bit of this and that - Honest mistakes and intentional deception* section for more information on rescissions.

  Any statement made is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

On the date your coverage ends, we will refund to the policyholder any prepayments for periods after the date your coverage ended.

Coverage cannot be terminated on the basis of:

- Health status
- Health care needs
- Because a **complaint** was filed with us

When will we send you a notice of your coverage ending?

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described above in "Why we would end your coverage").

Your coverage will end on either the date you stop active work, or the day before the first **premium** contribution due date that occurs after you stop active work.

Coverage will end for you and any dependents on the earlier of the date the group policy terminates or at the end of the period defined by the policyholder following the date on which you no longer meet the eligibility requirements.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a "qualifying event". COBRA usually applies to employers of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, which is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree health coverage and your former policyholder files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

Employer/group health plan notification requirements		
Notice	**Requirement**	**Deadline**
General notice – policyholder or **Aetna**	Notify you and your dependents of COBRA rights.	Within 90 days after active employee coverage begins
Notice of qualifying event – employer	• Your active employment ends for reasons other than gross misconduct • Your working hours are reduced • You become entitled to benefits under Medicare • You die • You are a retiree eligible for retiree health coverage and your former policyholder files for bankruptcy	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – policyholder or **Aetna**	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA **–** policyholder **or Aetna**	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice **–** policyholder or **Aetna**	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify the policyholder if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the policyholder if: • The Social Security Administration determines that you or a covered dependent qualify for disability status	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary's status change to non-disabled	Notify the policyholder if: • The Social Security Administration decides that the beneficiary is no longer disabled	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify the policyholder if: • You are electing COBRA	60 days from the qualifying event. You will lose your right to elect, if you do not: • Respond within the 60 days • And send back your application

How can you extend the length of your COBRA coverage?

The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • You divorce or legally separate and are no longer responsible for dependent coverage • You become entitled to benefits under Medicare • Your covered dependent children no longer qualify as dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?
You enroll by sending in an application and paying the **premium**. The policyholder has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?
Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?
For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% is added to cover administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?
You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the policyholder within 31 days of their eligibility.
- You pay the additional required **premiums**.

When does COBRA coverage end?
COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of coverage for other reasons
To request an extension of coverage**,** just call the toll-free Member Services number on your ID card.

How can you extend coverage if you are totally disabled when coverage ends?
Your coverage may be extended if you or your dependents are totally disabled when coverage ends.

You are “totally disabled” if you cannot work at your own occupation or any other occupation for pay or profit.

Your dependent is “totally disabled” if that person cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage until the earliest of:

- When you or your dependents are no longer totally disabled
- When you become covered by another health benefits plan
- 12 months of coverage

The extension of benefits shall not extend the time periods during which you and your dependents may:

- Enroll for continuation of coverage under any New Jersey Continuation law or COBRA
- Expand the benefits for such coverage or
- Waive the requirements concerning the payment of **premium** contribution for any continuation plan selected

Continuation coverage for dependents

If you die while covered under this plan, any coverage then in force for the dependents will be continued, provided the **contract holder** continues to make **premium** payments. Your spouse's coverage will cease when the spouse remarries. Any dependent's coverage, including a spouse's, will cease upon the earliest of:

- The end of the 12 month period right after your death
- A dependent no longer meets the eligibility requirements
- A dependent becomes eligible for like coverage under this plan or any other plan providing group health benefits
- When the **contract holder** no longer provides coverage for the class of eligible enrollees of which you were part right before your death
- Any required premiums cease

If coverage is being continued for a dependent, a child born after your death will also be covered.

How can you extend coverage when getting inpatient care when coverage ends?
Your coverage may be extended if you or your dependents are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends. If coverage is terminated or discontinued and you are hospitalized prior to the termination date, all charges with respect to hospitalization will be considered on the date of admission for all services and supplies provided through the date of discharge.

Benefits are extended for the condition that caused the **hospital** or **skilled nursing facility stay** or for complications from the condition. Benefits aren't extended for other medical conditions.

You can continue to get care for this condition until the earliest of:

- When you are discharged
- When you no longer need inpatient care
- 12 months of coverage

The extension of benefits shall not extend the time periods during which you and your dependents may:

- Enroll for continuation of coverage under any New Jersey Continuation law or COBRA
- Expand the benefits for such coverage or
- Waive the requirements concerning the payment of **premium** contribution for any continuation plan selected

Continuation of coverage during temporary lay-off or approved leave of absence

If your coverage would terminate due to a temporary lay-off or an approved leave of absence, coverage may be continued for up 60 days, or as otherwise agreed upon by the **contract holder** and **Aetna**, if the **contract holder**:

- Pays the **premium** for such continued coverage and
- Provides continued coverage from us or its other sponsored health benefit plans to all eligible enrollees in the same class as yours whose coverage would otherwise terminate because of a temporary lay-off or approved leave of absence.

How can you extend coverage for hearing services and supplies when coverage ends?

If your coverage ends while you are not totally disabled**,** your plan will cover hearing services and supplies within 30 days after your coverage ends if:

- The **prescription** for the hearing aid is written in the 30 days before your coverage ended.
- The hearing aid is ordered during the 30 days before the date coverage ends.

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability, and
- Depends mainly (more than 50% of income) on you for support.

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year beginning after the two year period following the child attaining the plan age limit as shown on the Schedule of Benefits. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

How can you extend coverage for a child in college on medical leave?

You have the right to extend coverage for your dependent college student who takes a medically necessary leave of absence from school. The right to coverage will be extended until:

- The earlier of one year after the leave of absence begins, or
- The date coverage would otherwise end, or
- The date your dependent child no longer is a dependent child according to Who can be on your plan (who can be your dependent) section.

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness** or **injury,**
- Cause the dependent child to lose status as a full-time student under the plan, and
- Be certified by the treating **physician** as medically necessary due to a serious **illness** or **injury.**

The **physician** treating your child will be asked to keep us informed of any changes.

Over-age dependent continuation

How can you continue coverage for over-age dependents?
A child who meets these conditions may elect to be covered under the **contract holder's** plan until his or her 31 birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends below.

Over-age dependent means your child by blood or law who:	• Has reached the limiting age as described in the *Who the plan covers – Who can be on your plan* section of this certificate, but is less than 31 years of age • Is not married or is not a domestic partner or is not in a civil union • Has no dependents of his or her own • Is either a resident of New Jersey or is enrolled as a full-time student at an accredited school • Is not covered under any other: - Group or individual health benefits plan - Group health plan - Church plan or health benefits plan • Is not entitled to Medicare on the date continuation coverage begins
Conditions for election An **over-age dependent** is only entitled to make an election for continued coverage if all of the following conditions are met:	• The **over-age dependent** must provide evidence of prior creditable coverage or receipt of benefits under: - A group or individual health benefits plan - A group health plan - Church plan or health benefits plan or - Medicare • The prior coverage must have been effect at some time prior to making an election for this **over-age dependent** coverage. • A parent of an **over-age dependent** must be enrolled as having elected dependent coverage at the time the **over-age dependent** elects continued coverage

Election of continuation The eligible **over-age dependent** may make a written election for coverage. The effective date of the continued coverage will be the later of:	• The date the **over-age dependent** gives written notice to us • The date the **over-age dependent** pays the first **premium** • The date the dependent would otherwise lose coverage due to attainment of the limiting age
• For a dependent whose coverage has not yet terminated due to the attainment of the limiting age	• Written election must be made within the 30 days prior to attainment of the limiting age. • If made later, it would result in a lapse of coverage.
• For a dependent who was not covered on the date he or she reached the limiting age,	• The written election may be made at any time.
• For a person who did not qualify as an **over-age dependent** because he or she failed to meet all requirements of an **over-age dependent**, but who subsequently meets all of these requirements	• Written election may be made at any time after the person meets all of the requirements.
Evidence of insurability is not required for the continued coverage.	
Continued coverage The continued coverage shall be identical to the coverage provided to the **over-age dependent's** parent covered under the plan. If coverage is modified for dependents under the limiting age, the coverage for **over-age dependents** shall also be modified in the same manner.	
• **Payment of Premium**	• The first month's **premium** will be determined by the effective date of the **over-age dependent's** election • Subsequent monthly **premiums** must be paid in advance, at the times and in the manner specified by **Aetna.**
• **Payment of Premiums Grace Period**	• First **premium** payment, 31 days after billing due date. • Subsequent **premium** payment is made within 31 days of the date it is due.

When continuation ends	
An **over-age dependent's** continued group health benefits end on the first of the following:	• The date the **over-age dependent**: - Attains age 31 - Marries or becomes a domestic partner or enters into a civil union - Acquires a dependent - Is no longer either a resident of New Jersey or enrolled as a full-time student at an accredited school or - Becomes covered under any other: ○ group or individual health benefits plan ○ group health plan ○ church plan or health benefits plan or ○ becomes entitled to Medicare • The end of the period for which **premium** has been paid for the **over-age dependent**, subject to the grace period for such payment • The date the plan ceases to provide coverage to the **over-age dependent's** parent who is covered under the plan • The date the plan under which the **over-age dependent** elected to continue coverage is amended to eliminate coverage for dependents • The date the **over-age dependent's** parent who is covered under the plan waives dependent coverage. Except, if you have no other dependents, the **over-age dependent's** coverage will not end as a result of your waiving dependent coverage.

What do you need to know?	• Once the **contract holder** has validated the parent of an **over-age dependent's** coverage, the *Temporary HINT Supplemental Enrollment Information Form* must be completed by the enrollee • We will bill the covered **over-age dependent** directly and enrollees will remit the **premium** directly to us. • Although you must continue eligibility under the plan for continued coverage of the dependent, the dependent must also meet the applicable eligibility rules. All cost sharing requirements and limitations will apply and will not be combined with your plan. **Covered benefits** incurred by the dependent will not contribute towards the family **deductible** and out-of-pocket maximums. Family incurred expenses will not contribute towards the **over-age dependent's deductible**s or out-of-pocket maximums. • The *When coverage ends* section of the certificate does not apply to an **over-age dependent**. • **Over-age dependents** who have made an election for continuation and whose coverage is later terminated are not eligible for the continuation provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or New Jersey Continuation under the group plan. • A dependent of an **over-age dependent** will not be covered for any **covered benefits** in the certificate. This would also include any newborn children.

Discontinuance and replacement provisions

This section determines a carrier's responsibility when one carrier's policy or contract replaces another carrier's plan providing similar types of coverage.

How is the responsibility between the prior carrier and new carrier determined?

Responsibility	Prior carrier	New carrier
Claims incurred on the day prior to the new carrier's effective date	Prior carrier	
Extension of benefits	Prior carrier	
This does not change even if the group policyholder, contract holder or other entity gets replacement coverage from a new carrier, decides to self-fund or decides to stop providing coverage.		
If you are eligible for coverage with the new carrier on the effective date of the new carrier's plan		New carrier
If you were covered under the prior plan on the date that plan ended and you are in an eligible class of covered employees on the effective date of the new carrier's plan		New carrier
If you are totally disabled on the date the prior carrier's plan ended	Prior carrier	

- The minimum amount of benefits to be provided by the new carrier are the prior carrier's plan minus any benefits payable or services or supplies provided by the prior plan.
- Coverage shall be provided by the new carrier until at least the earliest of the following:
  - The date the individual becomes eligible under the new carrier's plan
  - For each type of coverage, the date the individual's coverage would terminate in accordance with the new carrier's termination provision (for example, at termination of employment or ceasing to be an eligible dependent, as the case may be)
  - In the case of an individual who was totally disabled, and in the case of a type of coverage for which New Jersey law requires an extension of accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by New Jersey law

What happens to the time you have already satisfied for any benefit waiting periods?

The new carrier will give you credit for this time. Your employer will confirm the time already satisfied with the prior carrier.

A bit of this and that

We gathered a number of provisions here. They talk about several different things, so we call this part “a bit of this and that.”

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to federal laws and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet-certificate when we administer your coverage, so long as we use reasonable discretion. Our interpretation can be reversed by an internal utilization review organization, a court of law, arbitrator or administrative agency having jurisdiction. See the When you disagree-claim determination procedures/complaints and appeals section.

How we administer this plan

We apply policies and procedures we’ve developed to administer this plan.

Who’s responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your and your dependent's **providers**. Even **network providers** are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group accident and health insurance policy. This document may have amendments too. Under certain circumstances, we or the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **precertification**, prescription quantity limits or your cost share if you are affected. Only **Aetna** may waive a requirement of your plan. No other person – including the policyholder or **provider** – can do this.

If a service cannot be provided to you

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

We will try hard to get you and your dependents access to the services you and your dependents need even if these things happen. But if we can’t, we may refund you or the policyholder any unearned premium contribution.

Legal action

See the *When you disagree – claim determination procedures/complaints and appeals* section before you take legal action against us for any expense or bill. And you cannot take any action until 60 days after we receive written submission of claim.

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

Physical examinations and evaluations
At our expense, we have the right and opportunity to have a **physician** of our choice examine you and your dependents. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

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

Things that would be important to keep are:
- Names of **physicians**, dentists and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception
Honest mistakes
You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception
If we learn that you or your dependents defrauded us or you or your dependents intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:
- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

If we have reason to believe that a claim has been submitted fraudulently, we shall investigate the claim in accordance with our fraud prevention plan, or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to New Jersey Law. We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage.
- We will give you 30 days advanced written notice of any rescission of coverage.
- You have the right to an **Aetna** appeal.
- You have the right to a third party review conducted by an independent external review organization.

Some other money issues

Assignment of benefits

When you or your dependents see a **network provider** they will bill us directly. When you or your dependents see an **out-of-network provider,** we may choose to pay you or to pay the **provider** directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** or facility under this group policy unless it is an **emergency medical condition** or treatment for an **urgent condition.**

When you submit a claim for an **emergency medical condition** or treatment for an **urgent condition** situation and you assign your rights to receive reimbursement for covered services to an **out-of-network provider,** we are required to pay benefits in line with the assignment of benefits. We will directly pay the health care **provider** in the form of a check payable:

- To the health care **provider** or
- To the health care **provider** and you as a joint payee

with signature lines for each.

Any payment made solely to you rather than the health care **provider** under these circumstances shall be considered unpaid, and unless remitted to the health care **provider** within the time frames established by New Jersey Law, shall be considered overdue and subject to an interest charge as provided in that act.

Financial sanctions exclusions

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

Grace period

You will be allowed a grace period of 31 days after the due date for the payment of each contribution due after the first contribution payment. If contributions are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Premium contribution

This plan requires the policyholder to make **premium** payments. If payments are made through a payroll deduction with the policyholder, the policyholder will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** payments are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Payment of premiums

The first **premium** payment for this policy is due on or before your **effective date of coverage**. Your next **premium** payment will be due the 1st of each month ("**premium** due date"). Each **premium** payment is to be paid to us on or before the **premium** due date.

Recovery of overpayments

We sometimes pay too much for **eligible health services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – your **provider** – to return what we paid. However, we have to request reimbursement no more than 18 months following the date the first payment on the particular claim was made. We can only request one reimbursement per particular claim.

We will work directly with your **provider** throughout the reimbursement process.

Your health information

We will protect your and your dependents' health information. We will only use it and share it with others as needed for your care and treatment. We will also use and share it to help us process your and your dependents' **providers'** claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call the toll-free number on your ID card.

When you accept coverage under this plan, you agree to let your and your dependents' **providers** share information with us. We need information about your and your dependents' physical and mental condition and care.

Effect of benefits under other plans

Effect of a Health Maintenance Organization plan (a HMO plan) on coverage

If you are eligible and have chosen medical coverage under a HMO plan offered by the employer, you will be excluded from medical coverage (except vision care, if any,) on the date of your coverage under the HMO plan.

If you and your covered dependents:	**Change of coverage:**	**Coverage takes effect:**
Live in a HMO plan enrollment area	During an open enrollment period	Group policy anniversary date after the open enrollment period
Live in a HMO plan enrollment area	Not during an open enrollment period	Only if and when we give our written consent
Move from a HMO plan enrollment area or the HMO discontinues	Within 31 days	On the date you elect such coverage
Move from a HMO plan enrollment area or the HMO discontinues	After 31 days	Only if and when we give our written consent

Extension of benefits for pregnancy

If you are:	**Evidence you must provide:**	**Extension:**	**Extension will end the earlier of:**
In a hospital not affiliated with the HMO plan	The HMO plan provides an extension of benefits for pregnancy	Same length of time and for the same conditions as the HMO plan provides	• The end of a 90 day period, or • The date the person is not confined

No benefits will be paid for any charges for services rendered or supplies received under a HMO plan.

Effect of prior coverage - transferred business

Prior coverage means:

- Any plan of group coverage that has been replaced by coverage under part or this entire plan.
- The plan must have been sponsored by the policyholder (e.g., transferred business).
- If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

If your coverage under any part of this plan replaces any prior coverage, any benefits provided under such prior coverage may reduce benefits payable under this plan. See the *General coverage provisions* section of the schedule of benefits.

Health coverage under this plan will continue uninterrupted as to your dependent college student who takes a medically necessary leave of absence from school. See the *Special coverage options after your plan coverage ends – How can you extend coverage for a child in college on medical leave?* section.

Glossary

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

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

Autism service provider
Autism/Autism spectrum disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

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

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

Body mass index
This is a degree of obesity and is calculated by dividing your or your dependents weight in kilograms by your or your dependents' height in meters squared.

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

Coinsurance
The specific percentage you have to pay, if any, for a health care service listed in the schedule of benefits.

Copay/Copayments
The specific dollar amount or percentage you have to pay, if any, for a health care service listed in the schedule of benefits.

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

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

1. They are **medically necessary.**
2. You and your dependents received **precertification**, if required.

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

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

Detoxification
The process where a substance intoxicated, or substance dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating substance
- substance-dependent factors
- Alcohol in combination with drugs

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

Directory
The list of **network providers** for your plan. The most up-to-date directory for your plan appears at http://www.aetna.comunder the provider search label. When searching provider search, you and your dependents need to make sure that you and your dependents are searching for **providers** that participate in your specific plan. **Network providers** may only be considered for certain **Aetna** plans.

Durable medical equipment (DME)
Equipment and the accessories needed to operate it, that is:

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

Effective date of coverage
The date your and your dependents' coverage begins under this booklet-certificate as noted in **Aetna's** records.

Eligible health services
The health care services and supplies and **prescription drugs** listed in the *Eligible health services under your plan* section and not carved out or limited in the *What your plan doesn't cover – eligible health service exceptions* section or in the schedule of benefits**.**

Emergency medical condition

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

- Placing your or your dependents' health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus
- With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to affect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency services

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

Experimental or investigational

A drug, device, procedure, or treatment that we find is **experimental or investigational** because:

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

Formulary exclusions list

A list of **prescription drugs** not covered under the plan**.** This list is subject to change.

Generic prescription drug

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Group policy

The group policy consists of several documents taken together. They may be amended by operation of law. These documents are filed and approved by the New Jersey Department of Banking and Insurance. These documents are:

- The group application
- The group policy
- The booklet-certificate(s)
- The schedule of benefits
- Any amendments to the group policy the booklet-certificate, and the schedule of benefits

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

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

Home health care plan
A plan of services prescribed by a **physician** or other health care practitioner to be provided in the home setting. These services are usually provided after your or your dependents' discharge from a **hospital** or if you or your dependents' are homebound. All plans shall be in place within 14 days following the start of home health care.

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

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

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

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

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

Hospital does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance abuse**
- **Residential treatment facility** for **mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

Illness
Poor health resulting from disease of the body or mind.

Infertile/infertility

A disease defined by the failure to carry a pregnancy to live birth or to become pregnant:

- For a female with a male partner, after:
  1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older

- For a female without a male partner, after:
  At least 12 cycles of donor insemination if under the age of 35
  6 cycles of donor insemination if age 35 or older

- For a male with or without a female partner, after:
  Unsuccessfully being able to impregnate a female

Injectable drug(s)

Prescription drugs that are intended to be administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of covered **injectable drugs**, designated by **Aetna** as eligible for coverage, shall be available upon request by you and your dependents or may be accessed at our website, at www.aetna.com. The list is subject to change by **Aetna**.

Injury

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

Institutes of Excellence™ (IOE) facility

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

Intensive outpatient program (IOP)

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

Jaw joint disorder

This is:

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

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy

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

Maximum out-of-pocket limit

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

Medically necessary/Medical necessity

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

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **physician,** or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury** or disease
- With respect to **substance use disorder**, in accordance with an evidence-based and peer reviewed clinical review tool as designated in regulation by the Commissioner of Human Services

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Otherwise consistent with physician specialty society recommendations the view of **physicians** or dentists practicing in relevant clinical areas.
- Following the standards set forth in our clinical policies and applying clinical judgment.

With respect to **substance use disorder**, your provider will determine **medical necessity** for the first 180 days of treatment.

Mental disorder

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

Morbid obesity/morbidly obese

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

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

Negotiated charge

For health coverage, this is either:

- The amount a **network provider** has agreed to accept
- The amount we agree to pay directly to a **network provider** or third party vendor (including any administrative fee in the amount paid)

for providing services, **prescription drugs** or supplies to plan members. This does not include **prescription drug** services from a **network pharmacy**.

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us or an affiliate and a drug manufacturer for any **prescription drug**.

The rebates will not change the **negotiated charge** under this plan.

*For **prescription drug** services from a **network pharmacy**:*
The amount we established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts we agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may change the **negotiated charge** under this plan.

Network pharmacy

A **retail**, **mail order** or **specialty pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you.

Network provider

A **provider** listed in the **directory** for your plan. However, a NAP provider listed in the NAP directory is not a **network provider**.

Non-preferred drug

A **prescription drug** or device that may have a higher out-of-pocket cost than a **preferred drug**.

Out-of-network pharmacy

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

Out-of-network provider

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

Partial hospitalization treatment

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

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

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

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

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

For the purpose of Applied Behavior Analysis as included in the *Autism spectrum disorder and other developmental disabilities* section, **Physician** also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

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

Preferred drug
A **prescription drug** or device that may have a lower out-of-pocket cost than a **non-preferred drug**.

Preferred drug guide
A list of **prescription drugs** and devices established by **Aetna** or an affiliate. It does not include all **prescription drugs** and devices. This list can be reviewed and changed by **Aetna** or an affiliate. A copy of the **preferred drug guide** is available at your request. Or you can find it on the **Aetna** website at www.aetna.com/formulary.

Preferred network pharmacy
A **network retail pharmacy** that **Aetna** has identified as a **preferred network pharmacy**.

Premium
The amount you or the policyholder are required to pay to **Aetna** to continue coverage.

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

Prescription
As to hearing care:
A written order for the dispensing of **prescription** electronic hearing aids by otolaryngologist, otologist or audiologist.

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

As to vision care:
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

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

Primary care physician (PCP)
A **physician** who:

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

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

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

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

Recognized charge
The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge.** The **recognized charge** may be less than the **provider's** full charge.

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

Service or supply	**Recognized charge**
Professional services and other services or supplies not mentioned below	200% of the Medicare allowable rate
Services of **hospitals** and other facilities	200% of the Medicare allowable rate
Prescription drugs	110% of the average wholesale price (AWP)
Important note: If the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.	

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

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are services or supplies that are one of the following:
  - Performed at a network facility by an **out-of-network provider**, unless that **out-of-network provider** is an assistant surgeon for your **surgery**
  - Not available from a **network provider**
  - **Emergency services**

  We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other providers charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

  We may make the following exceptions:
  - For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
  - Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
  - For anesthesia, our rate may be at least 105% of the rate CMS establishes for those services or supplies.
  - For laboratory, our rate may be 75% of the rate CMS establishes for those services or supplies.
  - For **DME**, our rate may be 75% of the rate CMS establishes for those services or supplies.
  - For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate may be 100% of the rate CMS establishes for those medications.

Our reimbursement policies
We reserve the right to apply our reimbursement policies to all out-of-network services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

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

Our reimbursement policies are based on our review of:

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

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

Get the most value out of your benefits
We have online tools to help decide whether to get care and if so, where. Use the "Estimate the Cost of Care" tool on **Aetna's** secure member website. **Aetna's** secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to **Aetna's** secure member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

R.N.

A registered nurse.

Residential treatment facility (mental disorders)

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

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating **mental disorders**:

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

Residential treatment facility (substance abuse)

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

In addition to the above requirements, an institution must meet the following for Chemical Dependence Residential Treatment Programs:

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

In addition to the above requirements, for Chemical Dependence **Detoxification** Programs within a residential setting:

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

Retail pharmacy

A community **pharmacy** that dispenses outpatient **prescription drugs** at retail prices.

Room and board

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

Semi-private room rate

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

Service area

The geographic area where **network providers** for this plan are located.

Skilled nursing facility

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

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

Skilled nursing facility also includes a SNF, continuing care retirement community (CCRC), or a retirement community which operates a SNF on the premises of the community, regardless of whether Aetna Health Insurance Company has a contract with the SNF or the SNF at the CCRC or retirement community. The person must be a resident of the community and their provider shall refer the person to the SNF or the community's Medicare-certified skilled nursing unit, as applicable, rather than to a SNF separate from the facility or the community of origin, if:

- The SNF or the CCRC or retirement community with a SNF has the capacity to provide the services the person needs
- The provider, in consultation with the person or the person's family, determines that the referral is in the best interest of the person
- The SNF or the CCRC or retirement community with a SNF agrees to be reimbursed at the same **recognized charge** as similar **providers** for the same services and supplies in the same geographic area
- The SNF or the CCRC or retirement community with a SNF meets all applicable state licensing and certification requirements

Skilled nursing facility does not include institutions that provide only:

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

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

Skilled nursing services

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

Specialist

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

Specialty prescription drugs

These are **prescription drugs** that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these **specialty prescription drugs** by calling the toll-free number on your ID card or by logging on to your Aetna's secure member website at www.aetna.com.

Specialty pharmacy

This is a **pharmacy** designated by Aetna as a **network pharmacy** to fill **prescriptions** for **specialty prescription drugs**.

Stay

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

Substance abuse disorder

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent including withdrawal. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental disorder** that are a focus of attention or treatment

Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery or surgical procedures

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Telehealth

The use of information and communication technologies, such as:

- Telephones
- Remote patient monitoring devices
- Other electronic means

to support

- Clinical health care
- **Provider** consultation
- Patient and professional health-related education
- Public health
- Health administration
- Other services

in accordance with New Jersey state law.

Telemedicine

The delivery of **eligible health services** using:

- Electronic communications
- Information technology
- Other electronic or technological means

To bridge the gap between a **provider** and you, either with or without the assistance of another **provider** in accordance with New Jersey state law.

Telemedicine does not include the use, in isolation, of:

- Audio-only telephone conversation
- Electronic mail
- Instant messaging
- Phone text
- Facsimile transmission

Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

Therapeutic drug class

A group of drugs or medications that have a similar or identical mode of action. Or are used for the treatment of the same or similar disease or **injury**.

Urgent care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent condition

An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-in clinic

A free-standing health care facility. Neither of the following should be considered a **walk-in clinic**:

- An emergency room
- The outpatient department of a **hospital**

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

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

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

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

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

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

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

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

Benefit Mandates that apply to you based on where you live

There may be other state mandated benefits that apply to you if you do not live in the state of New Jersey. Please contact Member Services at the phone number listed on your ID card with any questions you may have on your plan of benefits.

Important information about organ and tissue donation

Each year, we're required to send you informational materials about organ and tissue donation and registration. This is required* as your health benefits plan is written in New Jersey.

For information on how to make an anatomical gift, including information on the registration of a gift in the Donate Life New Jersey registry, please use the following contact information, depending on where you live:

If you live in northern or central New Jersey, contact:

New Jersey Sharing Network
691 Central Avenue, New Providence, NJ 07974
Phone: **(800) 742-7365**
Email: info@NJSharingNetwork.org
Web address: **www.NJSharingNetwork.org**

If you live in southern New Jersey, contact:

Gift of Life Donor Program
401 N. 3rd Street, Philadelphia, PA 19123
Phone: **(800) DONORS-1 (800) 366-6771**
Email: info@donors1.org
Web address: **www.donors1.org**

If you live in another state, please find the organization for your state online at:
https://organdonor.gov/awareness/organizations/local-opo.html

If you have any questions, please call our customer service department at the phone number on the back of your ID card. Thank you.

***This notice is sent in compliance with Chapter 220 of the New Jersey Laws of 2017.**
Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company of New York and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

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Disclosures to covered persons regarding out-of-network treatment

This summary only provides an overview of how a covered person's health benefits plan covers out-of-network treatment. It is only guidance to help a covered person understand their out-of-network benefits. This summary does not alter your coverage in any way.

The covered person should refer to their individual policy, group policy, certificate or evidence of coverage (if employer group plan), or summary of benefits and coverages for more information about your out-of-network benefits and about coverages and costs for in-network treatment.

For additional information – including whether a health care professional or facility is in-network or out-of-network, examples of out-of-network costs and estimates for specific services - please contact us at: the toll-free telephone number on your member identification card. The hours of operation are Monday to Friday, 24 hours per day.

Or

Visit our website at: aetna**.com**
And select legal notices, state specific and scroll to New Jersey out-of-network claims.

Your policy covers:	**What this means:**	**How am I protected by NJ law?**
Medically necessary treatment on an emergency or urgent basis by out-of-network health care professionals/facilities	Emergency - You are covered for out-of- network treatment for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain; psychiatric disturbances and/or symptoms of substance use disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual or unborn child in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. This includes any further medical examination and such treatment as may be required to stabilize the medical condition. This also includes if there is inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery or such transfer may pose a threat to the health or safety of the woman or unborn child. Urgent – You are covered for out-of-network treatment of a non-life-	Except as discussed below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost-sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: **www.state.nj.us/dobi/consumer.htm.** Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the emergent/urgent medical services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of- pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled. If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the

	threatening condition that requires care by a health care professional within 24 hours.	amount to be paid for the medical services. The amount awarded by the arbitrator may exceed what the carrier has already paid to the out-of-network health care professional/facility; however, any additional amount paid by the carrier pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total allowed charge/amount for the service(s).

Your policy covers:	**What this means:**	**How am I protected by NJ law?**
Inadvertent out-of- network services	You are covered for treatment by an out-of- network health care professional for covered services when you use an in-network health care facility (e.g. hospital, ambulatory surgery center, etc.) and, for any reason, in- network health care services are unavailable or provided by an out-of-network health care professional in that in-network facility. This includes laboratory testing ordered by an in- network health care professional and performed by an out-of-network bio- analytical laboratory (e.g., imaging, X-rays, blood tests, and anesthesia).	Except as provided below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost- sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: **https://www.state.nj.us/dobi/consumer.htm**
		Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the inadvertent out-of-network services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled.
		If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the inadvertent out-of- network services. The amount awarded by the arbitrator may

		exceed what the carrier has already paid to an out-of-network health care professional/facility; however, any additional amount paid by the carrier pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total allowed charge/amount for the service(s).

Your policy covers:	**What this means:**	**How am I protected by NJ law?**
Treatment from out-of-network health care professionals/ facilities if in-network health care professionals/facilities are unavailable.	Plans are required to have adequate networks to provide you with access to professionals/facilities within certain time/distance requirements so you can obtain medically necessary treatment of all illnesses or injuries covered by your plan.	You can request treatment from an out-of-network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, often called a request for an "in-plan exception." Please see the Department of Banking and Insurance's guide at: **https://nj.gov/dobi/appeal/.**

Your policy covers:	What this means:	How am I protected by NJ law?
Voluntary out-of-network services	You are covered for treatment by an out-of- network health care professional/facility when you knowingly, voluntarily and specifically select an out-of-network health care professional/facility, even if you have the opportunity to be serviced by an in- network health care professional/ facility. We will cover voluntary out-of-network service at the plan coinsurance listed in your Schedule of Benefits. Member cost-share may vary by service and be subject to a plan deductible. Your Schedule of Benefits describes your cost-share for covered out of network services. Some covered out-of-network services require you to precertify them with Aetna. Please be advised that the allowed charge/amount (discussed above) is not the same as the amount billed by your Out-of-Network Health Care Professional/Facility, and is usually less. We calculate the allowed charge/ amount as explained in your Booklet/ Certificate. Please refer to the attached definition of recognized charges for details on how the plan pays covered voluntary out-of-network services.	Carriers must provide ready access to information about how to determine when a health care professional/facility is in- network. Please contact us if you have any questions about the status of a particular professional/facility. Additionally, health care professionals/ facilities must disclose to you, in writing or on a website, the plans in which they participate as in-network providers. Note, indications that a professional/facility "accepts" a certain health plan does not necessarily indicate in- network status. So, when seeking treatment, you can check with both us and your prospective health care professional/facility. Carriers must provide a method to enable you to be able to calculate an estimate of out-of-network costs when voluntarily seeking to use an out-of-network health care professional/facility. You can contact us via the methods above to obtain more information regarding the allowed charge/amounts for specific services if you can provide a current procedural terminology (CPT) code. If you do not have a CPT code, you can estimate your costs by: You can log into the Aetna secure member website to use the cost estimator tool to obtain an estimate of your costs for covered out of network services. If a service or procedure is not listed in the cost estimator tool in your secure member website, you can obtain an estimated cost by completing the appropriate Member Request for Estimate Form on our website. To use the cost estimator, please visit our site at: **https://www.aetna.com/health-care-professionals.html** and click the "login" button.

		For a price estimate form, please visit this section of **Aetna.com:** **https://www.aetna.com/individuals-families/member-rights-resources/rights/state-specific-information.html** Once on the page, scroll to New Jersey for the applicable form.
	You will be **responsible for payment of**: a) Your cost-sharing portion of the allowed charge/amount as disclosed above; PLUS, b) the difference between our allowed charge/amount and the amount the out-of-network health care professional/facility bills for the services (commonly referred to as the "balance bill").	You can also visit our website above for examples of the average costs (allowed charge/amount, billed amount, consumer responsibility without cost-sharing under plan) for ten more frequently billed out-of- network services.

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711,
Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697 (TDD).**

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna). If there is any variance between this notice and the plan documents, the information in your plan documents govern.

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Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge.** The **recognized charge** may be less than the **provider's** full charge.

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

Service or supply	**Recognized charge**
Professional services and other services or supplies not mentioned below	200% of the Medicare allowable rate
Services of **hospitals** and other facilities	200% of the Medicare allowable rate
Prescription drugs	110% of the average wholesale price (AWP)
Important note: If the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.	

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

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are services or supplies that are one of the following:
  - Performed at a network facility by an **out-of-network provider**, unless that **out-of-network provider** is an assistant surgeon for your **surgery**
  - Not available from a **network provider**
  - **Emergency services**

  We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other providers charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

  We may make the following exceptions:
  - For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
  - Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
  - For anesthesia, our rate may be at least 105% of the rate CMS establishes for those services or supplies.

- For laboratory, our rate may be 75% of the rate CMS establishes for those services or supplies.
- For **DME**, our rate may be 75% of the rate CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate may be 100% of the rate CMS establishes for those medications.

Our reimbursement policies
We reserve the right to apply our reimbursement policies to all out-of-network services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

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

Our reimbursement policies are based on our review of:

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

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

Get the most value out of your benefits
We have online tools to help decide whether to get care and if so, where. Use the "Estimate the Cost of Care" tool on Aetna's member website. **Aetna's** secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna's member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

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

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

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

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

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

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

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

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

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

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

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

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