IMPORTANT INFORMATION REGARDING THE
EAST TENNESSEE TECHNOLOGY PARK HEALTH AND WELFARE BENEFIT PLAN AND THE
EAST TENNESSEE TECHNOLOGY PARK RETIREE MEDICAL BENEFIT PLAN

The enclosed Summary Plan Description (SPD) describes the benefit plans available to eligible employees, spouses, and dependents through the East Tennessee Technology Park (ETTP) Health and Welfare Benefit Plan and the ETTP Retiree Medical Benefit Plan. If you are an employee of a DOE contractor other than URS | CH2M Oak Ridge LLC, you may be eligible for other benefit programs provided by your employer that are not described in these documents.

This SPD is based on legal documents (such as plan documents, certificates of coverages, summary insurance booklets, and insurance contracts) currently in effect. These documents provide further detail on benefit coverages as well as important exclusions, limitations, and requirements applicable to receive benefits. You may obtain a copy of any of the official legal documents for your coverages by contacting the Plan Administrator (for Plan Documents) or the applicable insurance company (for insurance certificates). Contact information is listed at the end of this SPD in the "General Information" section.

While every effort has been made to give you correct and complete information about your benefits, in the event of any conflict or inconsistency between this SPD and relevant legal documents with respect to benefits payable, the terms of the legal documents will control. The SPD will govern if the conflict or inconsistency relates to eligibility, except as described in the "State Insurance Mandates and Dependent Coverage" section in the Participation chapter. From time to time, there may be changes in the benefits and/or procedures under the benefit options contained in this Plan. In the case of a material change, you will be notified in writing of the change. Notices and announcements will normally be sent directly to you at the address that appears on your employer's records. For this reason, it is important that you notify your employer when you have a change of address. You should also keep announcements and notices with this SPD for your future reference.

Health and Welfare SPD

Summary Plan Description

East Tennessee Technology Park Health and Welfare Benefit Plan

(as amended and restated effective January 1, 2016)

Summary Plan Description updated January 1, 2018

This Summary Plan Description ("SPD") summarizes the major features of the benefits program for eligible participants and eligible retirees as of January 1, 2018. You should also refer to any applicable cover letter accompanying this SPD for changes and additions to the SPD.

As of January 1, 2018, this SPD applies to eligible employees at the following companies ("Participating Employers"):

- URS | CH2M Oak Ridge LLC ("UCOR")
- Four Rivers Nuclear Partnership, LLC
- Fluor-BWXT Portsmouth LLC
- Wastren Advantage, Inc. (as a participating subcontractor under Four Rivers Nuclear Partnership, LLC)
- Portsmouth Mission Alliance, LLC

The following companies who are Participating Employers had a status change in the Plan during 2016 or 2017 as of the date set forth below:

- Portsmouth Mission Alliance, LLC adopted the Plan as of April 25, 2016
- Wastren-EnergX Mission Support, LLC ("WEMS") ceased participating in the Plan as of April 24, 2016
- Wastren Advantage Inc. ceased participating in the Plan as of April 24, 2016 (as a participating subcontractor under WEMS)
- SEC Radcon Alliance ceased participating in the Plan as of November 27, 2016 (as a participating subcontractor under UCOR)
- CDM Federal Services, Inc. ceased participating in the Plan as of September 30, 2017 (as a participating subcontractor under UCOR)
- Fluor Federal Services, Inc. ceased participating in the Plan as of October 19, 2017
- LATA Sharp Remediation Services LLC ceased participating in the Plan as of October 19, 2017 (as a participating subcontractor under Fluor Federal Services, Inc.)
- Four Rivers Nuclear Partnership, LLC adopted the Plan as of October 20, 2017
- Wastren Advantage, Inc. adopted (readopted) the Plan as of October 20, 2017 (as a participating subcontractor under Four Rivers Nuclear Partnership, LLC)

You should not rely on the information in this SPD other than as a general summary of the features of the East Tennessee Technology Park Health and Welfare Benefit Plan (the "Plan").

This SPD is based on legal documents (such as plan documents, insurance contracts, certificates of coverages, summary insurance booklets, and insurance contracts) currently in effect. These documents provide further detail on coverage benefits as well as important exclusions, limitations, and requirements applicable to receive benefits. You may obtain a copy of any of the official legal documents for your coverages by contacting the Plan Administrator at the contact information listed at the end of this SPD in the "General Information".

While every effort has been made to give you correct and complete information about your benefits, in the event of any conflict or inconsistency between this SPD and relevant legal documents with respect to benefits payable, the terms of the legal documents will control. The SPD will only govern if the conflict or inconsistency relates to eligibility, except as described in the "State Insurance Mandates and Dependent Coverage" section in the Participation chapter. From time to time, there may be changes in the benefits and/or procedures under the benefit options contained in this Plan. In the case of a material change, you will be notified in writing of the change. Notices and announcements will normally be sent directly to you at the address that appears on your employer's records. For this reason, it is important that you notify your employer when you have a change of address. You should also keep announcements and notices with this booklet for your future reference.

The Plan, as amended and restated, is effective January 1, 2016. As of that date, the amended and restated Plan entirely supersedes and replaces all prior governing documents. The Plan has since been amended. The Plan was established to combine various health and welfare benefits in a single document. For purposes of the annual reporting requirement (on Form 5500) and for compliance with other laws, this Plan is considered a wrap plan, which means that this single document incorporates several different Benefit Options to comprise one plan for purposes of meeting the reporting and disclosure requirements under the Employee Retirement Income Security Act of 1976.

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WHAT'S INSIDE

This SPD contains important information on many of the benefit programs offered under the East Tennessee Technology Park Health and Welfare Benefit Plan (the "Plan"). Please read it carefully and maintain in your records.

AN OVERVIEW OF YOUR HEALTH AND WELFARE BENEFITS

The Plan offers you a variety of benefits and levels of coverage ("Benefit Options") from which you can choose if you meet certain eligibility criteria. All of the Benefit Options available under this Plan are listed below and described throughout this SPD, but you are only eligible for the Benefit Options listed in Appendix A as offered by your employer as a Participating Employer in this Plan. Eligibility criteria may also vary for each Benefit Option. You should refer to Appendix A at the end of this SPD to determine what Benefit Options you may receive as an eligible employee.

All Benefit Options available under this Plan that Participating Employers may choose to offer (Note that your Participant Employer may not have chosen to offer all of the Benefit Options. Please refer to Appendix A for the specific Benefit Options offered by your Participating Employer as well as any eligibility requirements or to Appendix B for Benefit Options offered to eligible retirees):

- Medical Coverage
- Dental Coverage
- Vision Coverage
- Long-Term Disability
- Life Insurance (Basic, Supplemental and Dependent)

Additional Benefit Options available to UCOR (See Appendix A for the specific Benefit Options offered by your Participating Employer as well as any eligibility requirements or to Appendix B for Benefit Options offered to eligible retirees:

- Accidental Death and Dismemberment (AD&D) or Special Accident Insurance for certain eligible employees
- Employee Assistance Program (EAP) and work/life benefit
- Business Travel Accident Insurance

Additional Benefit Options available only to UCOR:

- Health Care Flexible Spending Accounts
- Dependent Care Flexible Spending Accounts

References to these Benefit Options throughout this SPD apply only to the employees of the Participating Employers and eligible retirees for which such Benefit Options are available. You should refer to Appendix A for the specific Benefit Options offered by your employer and Appendix B for specific Benefit Options offered to eligible retirees.

The Plan does not pay your bills or pay you any cash benefits. Rather, the benefits provided by the Plan, (except for the Health Care Flexible Spending Account and the Dependent Flexible Spending Account offered to UCOR employees), consist only of the payment of some or all of the premiums on insurance contracts. If you incur covered expenses, or become entitled to cash benefits, it is up to the insurance carrier to pay those expenses (or pay the cash benefits, if applicable) to the extent provided in the insurance contract.

Introduction

We recommend you read the insurance booklets, certificates of coverage, and any other literature prepared by the insurance carrier, which describe the benefits and the procedure for receiving benefits under the insurance coverage or Benefit Options. If you do not have full versions of those documents, they are available upon request to the Plan Administrator. Any document comprising the SPD, including certificates of coverage, is available free of charge.

If you are not sure whether an expense or benefit is covered by insurance, you should ask the insurance carrier.

If you or your employer ceases to pay premiums on an insurance contract for any reason, your coverage under that insurance contract will terminate automatically as of the close of the last period for which the premium was paid in full. Unusual circumstances that are not in the normal course of business, as determined by the Plan Administrator in its sole discretion, will warrant a review by the Plan Administrator before coverage is terminated.

THIRD PARTY ADMINISTRATORS

For purposes of administrating the various Benefit Options under the Plan, the Plan Administrator has retained the services of certain independent third party administrators and insurance companies. Generally the third party administrator does not assume liability for benefits payable under this Plan; some third party administrators, however, may be designated as a "named fiduciary," as that term is defined by Employee Retirement Income Security Act (ERISA), for purposes of processing claims.

MORE INFORMATION

We encourage you to retain this SPD for future reference. If you have questions about your benefits, please contact the Benefits Administrator whose contact information is included in the "General Information" section at the end this SPD.

The role of your employer's benefits department with the Plan's insurers and third party administrators is to assist you with questions you may have about this Plan. However, statements made by such representatives do not have a binding effect on the Plan. If you need to bring or appeal a claim under this Plan, you should follow the formal claims and appeals procedures described in this SPD.

This SPD is based on legal documents currently in effect (such as plan documents, insurance contracts and summaries, and Coverage Booklets). These documents provide further detail on coverage benefits as well as important exclusions, limitations, and requirements applicable to receive benefits. You may obtain a copy of any of the official legal documents for your coverages by contacting the Plan Administrator at the contact information listed in the "General Information" at the end of this SPD.

RIGHT TO AMEND

UCOR, as the Plan Sponsor, and the Benefits and Investment Committee (BIC), as the Plan Administrator, reserve the sole discretionary right to modify, amend, suspend, or terminate the Plan, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by the Amendment Committee, UCOR's Board of Managers, UCOR's President and Project Manager, or its designee.

UCOR's decision to change or terminate the Plan could result from:

- Changes in federal or state laws governing employee benefits;
- Changes in an insurance contract or policy involving an insurance company;

- Changes in a collective bargaining agreement; or

- Any other reason.

If the Plan is modified, amended or terminated, you will be notified of the effect of such change to your Plan benefits or coverage. However, the modification, amendment or termination may be effective before you are notified, to the extent permitted by law. Subject to the terms of any collective bargaining agreement or applicable law, no consent of any employee or any other person will be necessary to modify, amend, suspend, or terminate the Plan described in this SPD.

PARTICIPATION

YOUR ELIGIBILITY

Generally, you are eligible for health and welfare benefits available under applicable Benefit Options described in Appendix A if you are described as an eligible employee of your employer who is a Participating Employer or if you are described as an eligible retiree in Appendix B.

Independent contractors and leased employees are not eligible to participate in the Plan.

If you are an eligible employee of a Participating Employer or an eligible retiree and receive disability income benefits pursuant to the terms of a short-term or long-term disability program maintained by a Participating Employer, you are eligible to participate in some or all of the Benefit Options (as described in the applicable Benefit Options in this SPD) if:

- you were eligible to participate in this Plan immediately prior to an illness or injury for which you are receiving disability benefits under an employer-sponsored short-term or long-term disability program, or

- you were eligible to participate in the Plan immediately prior to an illness or injury for which you have timely applied for, and are awaiting approval of, disability benefits under an employer-sponsored short-term or long-term disability program.

YOUR ENROLLMENT

Beginning of Coverage

Participation in the Plan does not begin unless you actually enroll, except for certain coverages that are provided automatically to eligible employees of certain Participating Employers as described in Appendix A or to eligible retirees as described in Appendix B. If you are a retiree, you are only eligible for the Plan if you are eligible to enroll in the East Tennessee Technology Park Retiree Medical Plan. If you are a newly hired employee, you will receive enrollment information from your employer, including an enrollment notice. The deadline for new hire enrollment in the Plan is within 31 days following the date of hire (or 31 days following the first date of new eligibility, if later).

Subject to certain exceptions and if you timely enroll for coverage, your coverage will begin on the date set forth in the insurance documents for each Benefit Option. If you have questions about when your coverage begins, you can contact the Benefits Administrator at the contact information listed at the end of this SPD.

Payroll deductions for your share of the coverage costs will begin as soon as administratively feasible based on your eligibility date and pay cycle. Your contribution for a pay cycle will not be pro-rated by how many days of coverage are provided during that pay cycle.

Preexisting Conditions

Benefits under the Long-Term Disability program may be limited if you have a disability due to a preexisting condition. See the “Disability” section of this SPD and the insurance contracts for details.

YOUR ELIGIBILE DEPENDENTS

Subject to certain limitations, your eligible dependents may also participate in the Plan. Your eligible dependents generally include your:

- ***Legal Spouse*** where “Spouse” means the individual who is your legal husband or your legal wife in a marriage (whether an opposite-sex or same-sex spouse).

Participation

- ***Children*** to age 26, which can include:

  - ✓ Your natural children;
  - ✓ Your stepchildren;
  - ✓ Your legally adopted children (including children placed with you for adoption);
  - ✓ A child age 26 or older who, because of a mental or physical disability, lives with you and depends on you for financial support if the child's disability occurred before the child attained age 26 and was covered under this Plan prior to attaining age 26 (or another limiting age under applicable state laws).
  - ✓ A child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO)(excluding child life and AD&D coverage);
  - ✓ For the medical, dental, and vision Benefit Options, a foster child placed with you through a legally accredited agency or by the courts; and
  - ✓ As required under applicable state law for participants who live in Louisiana, your grandchildren who are in your legal custody and have not reached age 26.

Different Dependent Eligibility Criteria for Certain Benefit Options

The Benefit Options may have different dependent eligibility criteria (e.g., the Dependent Care Flexible Spending Account, Dependent Life Insurance, Accidental Death and Dismemberment insurance, Business Travel Accident Insurance). Although some different dependent eligibility criteria are set forth below, please see the dependent eligibility criteria for each section of this SPD and applicable insurance documents and Coverage Booklets for more information.

For purposes of the Special Accident Insurance Benefit Option, a covered spouse must also be under the age of 70. Also for this Benefit Option, a covered child must be under the age of 19, unmarried, and rely chiefly on you for support. Children age 18 through age 27 who are unmarried full-time students and rely chiefly on you for support and maintenance are also eligible for this Special Accident Insurance Benefit Option.

For purposes of the Life Insurance Benefit Options, eligible children must be between the age of 4 months and age 19. However, children age 19 to age 23 may be eligible for this Benefit Option if the child is a full-time student at an approved school and not employed on a full-time basis.

State Insurance Mandates and Dependent Coverage

A number of states have laws requiring insurance companies to extend eligibility for coverage to a certain class of dependents that may not be reflected in the eligibility rules above. Those laws, if any, generally will be reflected in the Certificate issued to you by the insurance company. If you believe that an insurance company in your state is required by law to make insurance coverage available for your dependent(s), you should contact the Benefits Administrator using the contact information at the end of this SPD and request such coverage.

Proof of Dependent/Disabled Status

From time to time you may be required to provide documentation as proof of your spouse or dependent's eligibility status, including such items as a marriage certificate, birth certificate, or adoption papers. Failure to provide adequate documentation, upon request, may result in termination of coverage for the affected individual(s) without any coverage extension under COBRA. In addition, coverage of ineligible dependents is in violation of the Plan's terms. If you are identified as covering ineligible dependents, you may be subject to legal action and discontinued from Plan coverage.

Participation

A disabled child that is continuing coverage beyond any limiting age while he or she is disabled will be required to provide proof of a mental or physical disability, including the Social Security Administration Disability Award Notice, to continue coverage.

Qualified Medical Child Support Order ("QMCSO")

The Plan also provides medical coverage for your child pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"). A QMCSO is either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing your employer to cover a child as your dependent under the Plan for medical coverage. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid.

If the Plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. If you have any questions or you would like to receive, free of charge, a copy of the written procedures for determining whether a QMCSO is valid, please contact the Plan Administrator.

No Duplication of Coverage

You cannot be enrolled in this Plan as both a participant and a dependent. Also, no person may be covered as a dependent of more than one participant in the Plan, except with respect to the Special Accident Insurance Benefit Option.

Affordable Care Act ("ACA") Marketplace Enrollment (subject to prevailing law)

You may prospectively revoke your election for medical coverage under the Plan if you are eligible for and intend to enroll in new health coverage through the Affordable Care Act Marketplace (or "ACA Marketplace") (during its special enrollment period or annual open enrollment period) that is effective beginning no later than the day immediately following the last day of the Plan medical coverage that is revoked. The ACA Marketplace is a public government sponsored exchange that offers a variety of individual health coverage alternatives for U.S. citizens, some of which could be subsidized by the federal or state government in the form of premium tax credits. This "ACA Marketplace Enrollment" exception is not applicable to the Health Care Flexible Spending Account Program. If you purchase health coverage through the ACA Marketplace instead of electing coverage offered by your employer under this Plan, you will lose the employer contribution to your premiums for the medical, dental, and vision Benefit Options, if any, that are available to you for health coverage under this Plan. Note that the ACA Marketplace is different than the alternatives offered to eligible retirees in a private exchange under the retiree medical plan.

Medicaid Assistance Under Medicaid and the Children's Health Insurance Program ("CHIP")

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have premium assistance programs that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that provides assistance, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Participation

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer's plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

For more information on special enrollment rights, you can contact either of the following entities:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

COST OF COVERAGE

The cost of each Benefit Option will be provided to you each year automatically by your employer during annual enrollment. The provider network for each Benefit Option is described in the separate insurance documents for that Benefit Option and are incorporated by reference into this SPD. A list of providers under any network for a Benefit Option will be furnished automatically to you, without charge, as a separate document.

You may have the opportunity to pay for coverage under certain Benefit Options with pre-tax dollars deducted from your gross pay each pay period if your employer sponsors its own cafeteria plan. You should check with your employer's human resources department for more information. Using pre-tax dollars reduces your taxable income for federal, Social Security and (in most cases) state income tax purposes, making more of your paycheck available for you and your family. Using pre-tax dollars to pay for Plan benefits will not, however, reduce your coverage level for any Plan benefit that is based on your income (e.g., your coverage level of basic life insurance).

You may have to pay for coverage under some Benefit Options on an after-tax basis. This means that you pay for the cost of coverage with your already-taxed dollars (your take-home pay or your net income). Your after-tax contributions are also deducted from your paycheck each pay period. IRS rules determine how each benefit you receive is taxed.

If your employer pays for your life insurance benefits, your coverage is tax-free if your coverage does not exceed $50,000. If your employer-provided coverage exceeds $50,000, you will have imputed income and are taxed on the cost of the coverage over $50,000, which is added to your Form W-2 for tax purposes.

Please note: Using pre-tax dollars can affect any Social Security benefits you may eventually receive. This is because you do not pay Social Security (FICA) taxes on pre-tax dollars. If you earn less than the Social Security "taxable wage base" after making contributions to the Plan, your pre-tax contributions to the Plan will lower the portion of your wages that is subject to Social Security taxes. As a result, your Social Security taxes will be lower, which may, in turn, cause your Social Security benefits to be slightly lower when you retire or if you become disabled. The amount of benefit reduction will depend on the amount of your pre-tax contributions and how long you participate in the Plan before you retire. If you have any concerns, or if you need additional information, contact your local Social Security Administration office or consult your financial advisor about the effects of your participation in the Plan.

Please note: Coverage under the Plan is subject to your payment of any required contribution unless, in the case of a child who is eligible for coverage pursuant to a QMCSO, payment of the required contribution is made by a state agency.

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Remember that income tax laws change frequently, and these changes affect different individuals in different ways. Therefore, your employer cannot assure you that it will be to your advantage to participate in the Plan on a pre-tax or after-tax basis.

ENROLLMENT

Enrollment Opportunities

The Plan has three types of enrollment opportunities:

- Initial enrollment—You must enroll within 31 days of eligible employment;
- During annual enrollment—You must enroll during the enrollment period designated in the enrollment materials; and
- Within 31 days after you have a change in status or experience another event that allows you to make a mid-year election change (60 days may be allowed for very limited types of events related to state Medicaid assistance).

Enrolling

Upon becoming initially eligible and before each annual enrollment, you will receive enrollment information that will let you know how and when to enroll for coverage. To obtain medical coverage, you will be required to provide a valid Social Security number for yourself and each dependent that you wish to cover, as well as the date of birth for each covered person. A Social Security number will not be required for a child until the child's first birthday.

The elections you make will stay in effect for the entire Plan year (January 1 – December 31) unless you change them upon an event permitting a mid-year change in elections or during a subsequent annual enrollment period. See the "Changing Coverage During the Year" section for information on mid-year enrollment and changes.

Annual Enrollment

Each fall, your employer has an enrollment period for benefits for the following Plan year (January 1 – December 31). You must review your annual enrollment materials to know whether you need to take action or not. Every year can be different. Most annual enrollments are "active," requiring you to take action and make elections in order to have coverage. Some annual enrollments are "passive," meaning some or all of your previous benefit elections will remain in effect and you will not be required to make elections in order to have coverage.

IMPORTANT: For UCOR employees who want to participate in the Health Care and Dependent Care Flexible Spending Accounts as a Benefit Option, you will need to make an election for each Plan year in which you wish to participate in these programs. Your elections for these Benefit Options **will not** automatically continue from Plan year to Plan year, even if the annual enrollment is "passive" for other benefits. During annual enrollment, you must enroll for coverage and authorize the amount you want to deduct from your gross pay on a pre-tax basis, subject to certain maximums and IRS regulations. As a reminder for non-UCOR employees, check with your employer's human resources department for information about whether your employer offers a flexible spending account program that is not part of this Plan.

During annual enrollment, you may elect coverage under any of the applicable Benefit Options. The elections you make during annual enrollment generally take effect on the following January 1, the start of the new Plan year. See the "Coverage During Absences" section for special rules regarding enrollment after an unpaid leave of absence.

Participation

During annual enrollment, you may have the opportunity to:

- Switch from one medical option or dental option to another (if several options are offered in your location), add or drop dependents, or decline or add medical (including prescription drug), dental or vision coverage for the next calendar year.

- With respect to income protection—disability, life and accident coverage—you may be able to enroll for coverage (if not automatically provided), or increase or decrease the level of life insurance coverage for you or your dependents, subject to certain conditions. Certain other restrictions may apply. Please see the "Disability" and "Life and Accident" sections of this SPD for further details.

If you are on a leave of absence at the time of annual enrollment, your elections may be affected. Please contact the Benefits Administrator for further details.

Notwithstanding the above, if your premiums for benefits under this Plan have not been paid in full as of the first day of the annual enrollment period (occurring in the fall), you may not be eligible to participant in the plan for the next plan year beginning on January 1st.

Special Circumstances: Re-employment

If you leave your employer and subsequently return to work for your employer, the following rules will apply:

- If you are rehired within 30 days and within the same Plan year (January 1 – December 31), your prior elections will be reinstated if you are rehired into a benefits eligible position;

- If you are rehired more than 30 days after you terminate, you will be eligible to make new elections; or

- If you are rehired within 30 days but in the Plan year following the Plan year in which you terminated employment, you will need to make new coverage elections.

If you terminate and are rehired in the same year, special rules will apply to reimbursements from your Health Care Flexible Spending Account. For more information, see "How Your Flexible Spending Accounts Work" in the "Flexible Spending Accounts" section of this SPD.

Changing Coverage During the Year

As a general rule, you will be allowed to make coverage changes only if an event results in you, your spouse, or your dependents gaining or losing coverage eligibility under an employer-sponsored plan. Your change in coverage must be consistent with the event (sometimes called a "change-in-status" event or "life" event). For example, if you get married, you can change your level of medical coverage from employee only to employee plus dependent.

Each Participating Employer (or its designee), in its sole discretion, shall determine whether an event permits an election change and, if so, whether the election change is consistent with the event, in accordance with rules established by the IRS.

Election Period for Changing Coverages and Effective Date of Coverage

If you experience an event permitting you to change any of your health and welfare coverages, you must notify your employer's benefits department and make your election changes within 31 days after the event (60 days for a loss of eligibility for Medicaid or State Child Health Plan or a gain of eligibility for premium assistance under Medicaid or State Child Health Plan), or any longer period specified below. If timely made, coverage changes made due to a mid-year event are generally effective on the first of the month following a timely election change. Two exceptions are:

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- For enrollment of a child pursuant to a QMCSO, coverage will be effective as soon as administratively possible after the Plan Administrator determines the QMCSO is valid;

- For HIPAA special enrollment of a child as a result of birth, adoption or placement for adoption, coverage will be effective as of birth or the date on which you acquired the child (except for the life insurance Benefit Option which has a minimum age requirement of 4 months).

If you do not make a timely election, you will not be able to make a mid-year election and will have to wait until annual enrollment (or a subsequent election change event) to make any election changes.

The Plan Administrator reserves the right to require, at any time, appropriate documentation of your change in status or other event.

Important Notes Regarding Mid-Year Election Changes

- For changes in status resulting in either you or a dependent becoming ineligible, coverage automatically ends as of the event resulting in your or your dependent's ineligibility (except that medical, dental, and vision coverage extends through the end of the month for dependents losing eligibility due to reaching age 26). The mid-year election change will stop the premium deduction that relates to the cost of coverage.

- If you become divorced or legally separated or a dependent child is no longer eligible for coverage, your spouse or child will lose eligibility for medical coverage under the Plan on the day the event occurs (except that coverage extends through the end of the month for dependents losing eligibility due to reaching age 26). Please see "Medical Coverage Continuation Rights (COBRA)" later in this section for more information on COBRA for such individuals.

Unpaid Absences

The beginning of an extended unpaid absence could be a change in status permitting election changes. To assist you in determining whether your extended absence is paid or unpaid and triggers your right to make an election change, you should contact your employer's benefits department.

Coverage During Unpaid Absences

In the event you qualify for an unpaid leave of absence under your employer's leave of absence policy (like an Family Medical Leave Act (FMLA) leave or personal leave), your coverages may be impacted during your leave of absence. You should check with your employer's human resources department for information on how to keep coverage during an unpaid leave of absence.

Reinstatement of Benefits

If your coverage ceases (e.g., for non-payment of required contributions) during an approved leave of absence ("LOA") (including a medical, family, or military LOA), you will be permitted to elect to again participate in the Plan upon your return from the LOA as permitted under the applicable Benefit Options. Please refer to the Certificates of Coverage for each benefit Option for more information or contact your employer's human resources department.

Furlough Periods

A "furlough period" means a period of furlough implemented by your employer due to a failure by Congress to pass legislation to fund the Federal government and resulting in a shortage of operating funds to the employer. If your coverage under any Benefit Option is discontinued during a furlough period due to late or nonpayment of premiums (whether by you, your employer, or both) or other reasons relating to a furlough period, your coverage

will end on the last day of such insurance coverage. At the end of the furlough period, you will be allowed to have your benefits reinstated at the same level of benefits and coverage at the beginning of the furlough period. If coverage is continued through the furlough period, you will be responsible for your portion of any outstanding premium payments.

Allowable Mid-Year Change Events

Election changes may be allowed if you or your dependent experiences certain events. The election change must be on account of and correspond with a change-in-status event, as determined by the Plan Administrator (or its designee), and it must affect eligibility for coverage. Generally, the change-in-status events are:

- Change in Legal Marital Status (such as a marriage, death of a spouse, divorce, legal separation, or annulment);
- Change in the Number of Dependents (such as a birth of a child, the adoption or placement for adoption of a dependent, or death of a dependent);
- Change in Working Status that could affect benefit eligibility (such as termination or commencement of employment, strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly or union to non-union or part-time to full-time, incurring a reduction or increase in hours of employment, or similar change which makes the individual become eligible or loss eligibility for a particular Benefit Option);
- Dependent Eligibility Requirement (such as attaining a specific age); or
- Change in Residence.

This is only a summary of some of the permitted change-in-status events and is not all inclusive. Further, the Plan Administrator has discretion to determine that a change in coverage is allowed mid-year due to a certain event you experience and based on the terms of the Plan.

WHEN COVERAGE ENDS

Your Coverages End

Your coverages end upon the first of the following to occur:

- Your employment with your employer ends (e.g., you retire, quit or are terminated);
- You are no longer eligible to participate;
- You fail to timely pay your required contributions;
- You elect to terminate coverage;
- You knowingly make, or cause or permit to be made, false statements in order for you or another person to obtain Plan services or payment to which you or the other person are not entitled;
- The Plan Sponsor, UCOR, terminates the Benefit Option in whole or in part;
- Your employer is no longer a Participating Employer in this Plan (unless you are an eligible retiree);
- Coverage is terminated for the eligible class to which you belong;

- Your employer's contract to perform services as a first or second tier subcontract ends (unless you are an eligible retiree); or

- Your employer's contract to perform services as a new prime contractor or a new subcontractor ends (unless you are an eligible retiree).

Termination of your medical, vision, and dental coverages will be effective on the last day of the month in which the triggering event occurs. All other coverages terminate immediately upon your termination of employment or other triggering event.

Your Dependent's Coverages End

Your dependent's coverage ends upon the first of the following to occur:

- You fail to submit requested documentation of dependent status in connection with a dependent coverage verification;

- When your coverage ends;

- Your dependent no longer meets the eligibility requirements; or

- You cease to be a participant in this Plan.

Termination of medical, vision, and dental coverage for your child due to your child attaining age 26 is effective on the last day of the month that includes the child's 26th birthday.

ADMINISTRATION

Administration

COORDINATION OF BENEFITS

Your medical coverage is fully insured by an insurance carrier. The Coverage Booklets made available by the insurance carrier (the "Coverage Booklets") provide more detail with regard to coordination of benefits, whether with other plans or with Medicare. See the General information section for how to access these Coverage Booklets.

SUBROGATION AND REIMBURSEMENT

Your medical coverage is fully insured by an insurance carrier. The Coverage Booklets made available by the insurance carrier (the "Coverage Booklets") provide more detail with regard to the Plan's subrogation rights. See the General information section for how to access these Coverage Booklets.

If you receive or become eligible to receive any medical, dental, or disability benefit arising from an accident, injury, or illness for which you can assert any claims or rights to recovery against a third-party, then any payments under this Plan are made on the condition that you will reimburse this Plan for any amounts you receive from a third-party as a result of an accident, injury, or illness, you will serve as a constructive trustee over the funds that constitute that payment, and a failure to hold such funds in trust shall be deemed a breach of your fiduciary duty to the Plan. The "make whole doctrine" arising under Federal common law and under State law does not apply to this Plan's reimbursement or subrogation rights. The Plan Administrator, in its sole discretion, may determine to reduce the reimbursement to the Plan from you by attorneys' fees and other expenses paid by you during your recovery against a third-party.

LIFE INSURANCE AFTER YOU LEAVE

This section provides a brief description of the conversion, portability, and continuation rights you may have for certain insured benefits. For more information about your rights, as well as terms, limitations and restrictions, please refer to the insurance documents, including your certificate of coverage, for the specific insured Benefit Option. You may also contact the insurance company to request these documents and obtain more information about possible coverage after you leave your current employer.

***Conversion Rights*.** These rights apply to employee basic and supplemental life insurance; accidental death and dismemberment; and dependent life insurance. You or your dependent may convert to an individual policy if your employment with your employer ends, you become ineligible for coverage, or your employer ceases participating in the Plan so that group life insurance terminates (limited rights apply in this circumstance). To timely convert to an individual policy, you or your dependent must apply for conversion with the appropriate insurance company listed in the "General Information" section at the end of this SPD and pay the first premium within 31 days after your coverage ends.

Portability Rights. These rights apply to salaried employee supplemental life insurance. If you have supplemental life insurance coverage (including dependent coverage) and your coverage ends, you may elect to continue group coverage for yourself and/or your dependent under a portability plan by paying the premiums due directly to the insurance company instead of converting the coverage to an individual policy. You must apply within 31 days after your coverage ends and, unlike your right to convert, Evidence of Insurability may be required. Generally, your portability rights are in lieu of your conversion rights.

Administration

HEALTH CARE COVERAGE CONTINUATION RIGHTS (COBRA)

A federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) allows you and your covered dependent (including your covered spouse or child) to continue your medical, dental and vision care on an after-tax basis in certain situation when existing coverage would otherwise end. For UCOR eligible employees only, COBRA is also available for you and your covered dependents to continue the Health Care FSA coverage on an after-tax basis in certain situations when existing coverage would otherwise end. Upon a qualifying event (described below), you and your covered dependents may be able to continue these coverages. If otherwise eligible, you and each of your covered dependents have an independent right to elect COBRA continuation coverage.

Electing COBRA

If you and/or your dependents choose continuation coverage through COBRA, you and your covered dependents are offered coverage on the same basis as other participants, except you or your affected dependents pay the entire cost plus a 2% administrative fee (or a 50% administrative fee in the case of an 11-month extension due to disability). COBRA coverage is intended to extend the coverage that is in effect for you and your covered dependents on the day before your qualifying event. COBRA coverage does not create new classes of covered individuals. To be eligible for continuation of coverage, your employer-provided health care coverage must be in effect on the date before the qualifying event. For your dependents to be eligible for continuation of coverage, they must also be enrolled for coverage on the day before the qualifying event.

As noted above, if you elect COBRA coverage, you will receive the same coverage that was in effect on the day before the qualifying event. However, you may change your coverage choices during the annual enrollment period that falls during your COBRA continuation coverage period. If your covered dependents elect COBRA, these same rights apply.

COBRA coverage takes effect on the date coverage is lost on account of the qualifying event if a timely election is made. While your employer will notify its COBRA Administrator of your qualifying event in the case of your termination from employment (or service, as applicable), reduction in hours or death, it is your (or your covered dependent's) responsibility to notify the COBRA administrator of any other qualifying event (e.g., divorce, child reaching age 26). In addition, you may add a newborn or an adopted child during the COBRA continuation period in accordance with the HIPAA "special enrollment" rules outlined earlier. Your newborn or adopted child's coverage begins immediately.

Reporting a Qualifying Event

You or your affected covered dependent must notify the Benefits Administrator either in writing or orally within 60 days after the date on which coverage is lost on account of any of the following qualifying events:

- You divorce or become legally separated;
- Your child no longer meets the definition of a dependent (e.g., due to age limit); or
- You (or your covered dependent) are determined to have been disabled under the Social Security Act when coverage ended or at any time during the first 60 days of receiving COBRA continuation coverage.

When you or your affected covered dependent contact the Benefits Administrator, be sure to inform them of the specific event, the date of the event and who is affected. Please note that you may be required to provide documentation concerning the qualifying event.

The COBRA Administrator sends you and/or your affected covered dependent a notice and election form, including the cost of coverage, within 14 days of receiving this notification.

Administration

Your employer informs the COBRA Administrator within 30 days of the loss of your coverage on account of any of the following qualifying events:

- Reduction in hours that makes you ineligible for coverage;
- You are laid off;
- You do not return from an FMLA leave of absence;
- Your termination of employment (or service, as applicable) for any reason other than gross misconduct;
- You become entitled to Medicare; or
- Your death.

The COBRA Administrator sends you and/or your affected covered dependents a notice and election form, including the cost of coverage, within 44 days after one of these qualifying events occur.

Snapshot of COBRA Coverage

Below is a snapshot of who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues for health care coverage. If one of the events listed in the chart occurs, you and your enrolled dependents may apply for COBRA coverage.

Qualifying Event	Who Is Eligible for COBRA	Maximum COBRA Period*
Termination of your employment (or service, as applicable) for any reason except gross misconduct	You and your enrolled dependents	18 months
Reduction in hours of employment (including a military leave of absence)**	You and your enrolled dependents	18 months
You become laid off	You and your enrolled dependents	18 months
You do not return from an FMLA leave of absence	You and your enrolled dependents	18 months
You or your covered dependent become disabled	You and your enrolled dependents	18 months up to 29 months***
Your death	Your enrolled dependents	36 months
Divorce or legal separation (unless a QMCSO provides otherwise)	Your enrolled dependents	36 months
Your child no longer meets the definition of dependent under the Plan	Your covered dependent	36 months

**The maximum COBRA period is measured from the date you lose coverage on account of the qualifying event. If your qualifying event is termination of employment or reduction in hours of employment and you became entitled to Medicare less than 18 months before the date coverage ended, the maximum COBRA period for your enrolled dependents lasts until 36 months after the date you became entitled to Medicare. If eligible for COBRA under the Health Care FSAs, the maximum COBRA period is through the end of the calendar year in which the qualifying event occurs. See "Health Care Flexible Spending Account" below for details.*

***Note that in the event you become entitled to COBRA coverage due to a loss of coverage triggered by a military leave of absence covered by the USERRA, you will receive continued coverage at the same cost paid by active employees for the first 30 days of your military leave. Also, your continuation coverage period is 24 months, not 18 months.*

****See "COBRA Coverage for Disabilities" below for details.*

Administration

Deciding Whether or Not to Continue Coverage

You have 60 days from the day coverage would otherwise end (or from the day the notice is sent to you, if later) to choose continuation coverage.

In order to continue your health care coverage, you and/or your covered dependents must pay the full cost of coverage, plus a 2% fee for administrative costs (or, in the case of an 11-month extension due to disability, up to a 50% administrative fee as determined by the COBRA Administrator).

Your first payment (due within 45 days of your election) must include your COBRA contribution for the entire period from the date coverage ended through the month of the payment. Subsequent contributions are due on the first of the month, whether or not you receive a bill. If the COBRA Administrator does not receive your monthly contribution within 30 days of the first of the month, coverage is canceled as of the last day of the month in which you paid a contribution. If you do not choose to continue coverage, you should make the appropriate election on the election form and return it to the COBRA Administrator. In that case, your health care coverage ends on the day on which the qualifying event occurred.

Ending Continuation Coverage

Continuation coverage ends when any of the following events occurs:

- You (or a covered dependent) reach the end of the applicable maximum COBRA period for coverage;
- You (or a covered dependent) do not pay a monthly contribution within 30 days of its due date;
- Upon your or your covered dependent's written request to cancel coverage;
- You (or a covered dependent) become entitled to Medicare after the COBRA event;
- You (or a covered dependent) subsequently become covered under another group medical or dental plan that does not contain a preexisting condition rule; or
- Your employer ceases to provide any group health plan coverage.

Please inform the Benefits Administrator of any changes in address or in personal circumstances so that you and your covered dependents can receive the necessary information concerning your rights to continuation of coverage. However, if you are already receiving COBRA, please contact the COBRA Administrator to update any changes in address or in personal circumstances.

COBRA Coverage for Disabilities

COBRA coverage can be extended from 18 months up to 29 months if you (or another qualified beneficiary) are totally disabled when you (or the other qualified beneficiary) become eligible for COBRA coverage or become disabled during the first 60 days of COBRA coverage. Monthly contributions for continuation coverage may increase to 150% (from 102%) of the monthly amount for each of the 11 additional months of continuation coverage (any covered dependents can also continue their COBRA coverage during this extension period).

To be eligible for this extension, the individual must:

- Receive a determination of disability from the Social Security Administration (SSA) that the individual was disabled on the date coverage ended, or became disabled during the first 60 days of COBRA coverage, and

- Notify the Benefits Administrator prior to expiration of the original 18 month coverage period and within 60 days after the later of:
  - ✓ The date of the SSA's determination of disability; or
  - ✓ The date of the qualifying event.

If the SSA determines that the individual is no longer totally disabled, continuation of coverage will cease. The individual must notify the COBRA Administrator listed at the end of this SPD within 30 days of any such finding. Coverage will terminate on the earlier of the first day of the month that is at least 30 days after the SSA's findings or at the end of the 29-month period.

Health Care Flexible Spending Account ("Health Care FSA")

If you participated in the Health Care FSA as an eligible active employee of UCOR, you and your covered dependents are also permitted to elect COBRA continuation coverage for the Health Care FSA upon a qualifying event, provided you have not received reimbursement for amounts that exceed the balance in your Health Care FSA as of the date the qualifying event occurs (i.e., you have not "overspent" your Health Care FSA). In this case, you would continue contributions on an after-tax basis. The COBRA rules discussed in this section are the same, except that the maximum period for which you may continue after-tax contributions to your Health Care FSA is the remainder of the Plan year in which the qualifying event occurs.

Administration of COBRA

If you have any questions about COBRA or if you are required to notify your employer of any event to trigger COBRA obligations, please contact the Benefits Administrator. Upon any required notification by you, the Benefits Administrator will contact the COBRA Administrator to send you any necessary paperwork. The Plan Administrator has engaged a COBRA Administrator to assist with the sending and receiving of COBRA information, including the collection of COBRA premiums if elected by participants.

State Continuation Coverage

Certain states, such as California, provide for continuation coverage extending beyond the date your federal COBRA coverage ends. You should contact your insurer at the address listed in the Coverage Booklet provided by the insurer for more information.

Other Coverage Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Displaced Worker Medical Benefit Program (through the Department of Energy), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

CLAIMS AND APPEALS

CLAIMS AND APPEALS

CLAIMS AND APPEALS

This section reviews what you need to do to file claims for the different Benefit Options in the Plan. If you have any questions about filing claims, please call the appropriate administrator as listed in the General Information section at the end of this SPD. You may also contact the insurance company for more information about the claim procedures for a specific Benefit Option. If your initial claim for benefits is denied, you should follow the claims and appeals procedures described in the applicable insurance documents for that Benefit Option. If there is no such procedure under the applicable insurance documents that governs the disposition of a claim or dispute, or such procedure violates applicable law, then the claims procedure described in these procedures shall govern.

The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated participants. You and your Plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Types of Claims

There are two general types of claims: a claim regarding eligibility or enrollment, and a claim for benefits.

Claim Regarding Eligibility or Enrollment. This is a claim involving eligibility under a Benefit Option or enrollment in a Benefit Option. The Plan Administrator, generally determines these types of claims. If you are denied disability or life coverage because you did not satisfy an insurance requirement for coverage (e.g., Evidence of Insurability), any inquiries or claims should be directed to the Claims Administrator (who is the insurance company for the coverage). These are referred to as "Eligibility Claims" below.

Claim for Benefits. A claim for benefits is the more common type of claim and is a request that benefits be paid under the applicable program or, with respect to the Health or Dependent Care FSAs, a request that expenses be reimbursed. These are referred to as "Benefit Claims" below.

Filing Initial Benefit Claims

You may or may not need to file an initial claim to receive benefits. For a medical coverage with a network provider, if you receive in-network services, you do not need to file a claim—the provider should do that for you. However, if you receive non-network medical services you will be responsible for filing your own claims.

For more information regarding the claims filing process, see the insurance documents and certificate for your Benefit Option.

Timely Filing of All Claims

You should make every reasonable effort to file claims promptly after you incur services. In most cases you have up to 12 months from the date of service to file your claim. Claims filed or received after 12 months are not generally eligible for payment.

IF A CLAIM IS DENIED

If your claim for benefits under the Plan is denied, in whole or in part, you may have it reviewed in accordance with the following claims review procedures. The procedures will vary depending on the type of benefit claim it is. It is important to follow the procedures explained below. If you do not follow these procedures, you may be giving up important legal rights, such as the ability to file a claim in a court of law. If the procedures below are exhausted and you are not satisfied with the decision that has been made, you have the right to file a lawsuit.

These review and appeal procedures are governed by federal regulations. If anything described below is contrary to what federal regulations and other federal guidance would require, the federal information will control. The procedures are different depending on the type of benefit that is involved, which is explained below and in the applicable insurance documents for the Benefit Option.

Denial of Claims by the Insurance Company who is a Claims Administrator

If your claim for an insured or third-party benefit is denied under the Plan, you should refer to the applicable insurance policy or insurance Certificate of Coverage provided by the carrier, or contact the insurance carrier (see the General information section) for more information on the applicable claims procedures for the insurance company. The claim or dispute shall first be disposed of in accordance with the insurance documents governing each Benefit Option, including all time limitations thereunder. The insurance company providing the benefit under a Benefit Option is the "named fiduciary" for purposes of such Benefit Option. If there is no such procedure under the applicable insurance documents that governs the disposition of a claim or dispute, or such procedure violates applicable law, then the claims procedure described in these procedures shall govern.

Claims Process

Filing an Eligibility Claim

If you believe that you or your dependent is eligible or entitled to enroll under the Plan or a specific Benefit Option, you may file a claim in writing with the **Plan Administrator.** You must submit claims for all benefits to the Plan Administrator (or its designee) within one year from the date service was provided. If you do not submit claims for benefits within one year from the date service was provided, you will be ineligible to receive reimbursement from the applicable Benefit Option for any expenses incurred, and you will be responsible for payment of all expenses incurred. You will be entitled to a review of your claim file and to present evidence and testimony as part of the claim and appeal process.

Initial Benefit Claims

Benefit Claims that are Not Medical or Disability Claims: When a claim is received that is not a medical or disability claim, the Plan Administrator or Claims Administrator must notify you of its benefit determination within 90 days of the receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved.

Benefit Claims for Disability: When a benefit claim is received that is a disability claim, you will be notified of the benefit determination within a reasonable period of time, but no later than 45 days after your claim is received, unless an extension of up to 30 days is necessary due to matters beyond the control of the Plan and the Plan Administrator determines and notifies you (or your authorized representative) that such an extension is necessary before the expiration of the initial 45-day period. If, prior to the end of the first 30-day extension period, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that you (or your authorized representative) is notified prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. The notice of the extension shall specifically explain the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You (or your authorized representative) will be afforded at least 45 days within which to provide the specified information.

Benefit Claims for Medical: When a medical benefit claim is received that is a Pre-Service claim (as defined below) that are not Urgent Care claims (as defined below), an initial decision will be made within 15 days of the receipt of the claim. An extension of 15 days will be allowed for processing the claim if special circumstances are involved. If the extension is necessary because you did not submit the information necessary to decide the claim, the notice will describe the required information, you will be given at least 45 days from the receipt of the notice to provide information, and the period of time for deciding your claim will be tolled. Pre-Service claims for Urgent Care will be treated as Urgent Care claims. In the case of a failure to follow the Claim Procedures for filing a Pre-Service Claim, you (or your authorized representative) will be notified of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible but no later than 5 days following the failure. This notification may be oral, unless you (or your authorized representative) request written notification.

When a medical benefit claim is received that is an Urgent Care claim (including Pre-Service claims for Urgent Claim), an initial decision will be made as soon as possible, but no later than 72 hours after your claim is filed.

If insufficient information is received, you will be notified as soon as possible, but not later than 24 hours after receipt, of the specific information necessary for the Plan Administrator or its designee to make a decision on your claim. You must provide the requested information within a reasonable time, but no less than 48 hours after notification. You will be provided a determination within 48 hours after the earlier of receipt of the requested information or the end of the period within which you were requested to provide such additional information. In the case of a failure to follow the Claim Procedures for filing an Urgent Care claim, you (or your authorized representative) will be notified of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible but no later than 24 hours following the failure. This notification may be oral, unless you (or your authorized representative) request written notification.

When a medical benefit claim is received that is a Post-Service claim, an initial determination will be made on your claim within 30 days of the receipt of the claim, unless an extension of up to 15 days is necessary due to matters beyond the control of the Plan. The initial time period may be extended for up to 30 additional days if special circumstances are involved. If the extension is necessary because you did not submit the information necessary to decide the claim, the notice will describe the required information, you will be given at least 45 days from the receipt of the notice to provide information, and the period of time for deciding your claim will be tolled.

When a medical benefit claim is received that is a Concurrent Care claim, it will be treated as a Pre-Service claim described above. If you request to extend the course of treatment beyond the time period or number of treatments and such claim involves Urgent Care, your claim shall be decided as soon as possible, taking into account the medical exigencies. You will be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. The appeal of such determination shall be governed as an Urgent Care claim, a Pre-Service claim, or a Post-Service claims, as applicable.

Types of medical benefit claims:

- A “Pre-Service” claim is any claim for a benefit under a group health plan with respect to which the applicable Benefit Option requires you to obtain approval in advance of receiving the medical care.

- An “Urgent Care” claim is any claim for medical care under a group health plan with respect to which the applicable time periods for the Plan Administrator (or its designee) to make a non-urgent service claim determination could either seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without urgent care or treatment. The Plan Administrator (or its designee) will defer to the attending provider as to whether a claim is an Urgent Care claim.

- A “Post-Service” claim is any claim for a benefit for medical care previously rendered to you.

- A “Concurrent Care” claim is a claim for which the Plan Administrator (or its designee) approves ongoing treatment to be provided over a period of time.

Extensions: You will be given notice of any such extension within the time periods described above. The notice will state the special circumstances involved and the date a decision is expected. If an extension is necessary because of your failure to submit information necessary to make a decision, the period for making the decision will be tolled from the date on which the notice of extension is sent until the date you respond to the request for additional information. If the information requested is not provided with the extension period, your claim will be decided without the necessary information.

Determination of Initial Claim (for both Eligibility Claims and Benefit Claims)

The Plan Administrator or the Claims Administrator (or its designee) will send you a written notice of how the claim was decided, such as an adverse determination. For purposes of the claim and appeal processes, an “adverse determination” includes a denial, reduction, termination of, failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on a determination of your eligibility to participate in the Plan or any Benefit Option, a determination that a benefit is not a covered benefit, the imposition of a limitation on otherwise covered

benefits (such as a network exclusion), or a determination that a benefit is experimental, investigational, or not medically-necessary or appropriate. An "adverse determination" also includes rescission of the coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect, but does not include a rescission if the cancellation or discontinuance of coverage has only prospective effect or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

An adverse determination for denial of a claim will include:

- The reason(s) for the denial;
- References to the specific plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the plan's appeal procedures and the time limits applicable to the appeal process;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on appeal;
- In the case of a disability benefit claim, you will be notified of or given a statement of any internal rule, guideline, protocol, or other similar criteria that was relied upon in making the adverse determination and that a copy of such criteria will be provided free of charge upon request;
- In the case of a disability benefit claim or medical benefit claim that was based on a medical necessity or experimental treatment or similar exclusion or limit, you will be given either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- In the case of a medical benefit claim, information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the meaning of such codes);
- An explanation of how to request diagnosis and treatment codes (and their corresponding meanings);
- In the case of a medical benefit claim, available external review processes and the time limits;
- In the case of a medical benefit claim, the contact information for any applicable consumer assistance office established under Section 2793 of the Public Health Service Act to assist you; and
- In the case of a medical benefit claim that is an Urgent Care claim, a description of the expedited review process. Further, in the case of a medical benefit claim that is an Urgent Care claim, the information may be provided to you orally within the appropriate time frame followed by a written or electronic notification within 3 days after the oral notification.

You may request and receive, free of charge, reasonable access to and copies of relevant documents, records, and other information in the Plan's possession. Relevant documents, records, and other information are those that were relied on in making the benefit determination, were submitted/considered/generated in the course of making the benefit determination, demonstrate compliance with the Plan's or Benefit Option's administrative processes or safeguards, or in the case of a group health plan claim, constitute a statement of the Plan's or Benefit Option's policy or guideline regarding the benefits for your diagnosis, whether or not relied upon.

Appealing an Eligibility Claim or Benefit Claim Denial

Appeals that are Not Medical or Disability Claim Denial Appeals: If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator (or its designee) in writing within 60 days after your receipt of denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. The Plan Administrator decision on appeal usually will be made within 60 days after receiving your appeal,

unless special circumstances require an extension of an additional 60 days. If the period is extended, the Plan Administrator will notify you in writing of the extension within 60 days of receiving your appeal.

Appeals that are Disability Claim Denial Appeals: If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator (or its designee) in writing within 180 days after your receipt of denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. The review given to your appeal will not afford deference to the initial adverse determination and will be conducted by an appropriate fiduciary who is not the same individual who made the initial adverse determination that is the subject of the appeal, nor the subordinate of that individual. If your appeals involves an adverse determination that is based in whole or in part on a medical judgment, including determinations of whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved or in medical judgment. This professional will be an individual who was not consulted in connection with the initial adverse determination that is the subject of your appeal nor a subordinate of that individual. The Plan will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial adverse determination, without regard to whether the advice was relied upon in making the determination.

Appeals that are Medical Claim Denial Appeals: If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator (or its designee) in writing within 180 days after your receipt of denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. The review given to your appeal will not afford deference to the initial adverse determination and will be conducted by an appropriate fiduciary who is not the same individual who made the initial adverse determination that is the subject of the appeal, nor the subordinate of that individual. If your appeals involves an adverse determination that is based in whole or in part on a medical judgment, including determinations of whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved or in medical judgment. This professional will be an individual who was not consulted in connection with the initial adverse determination that is the subject of your appeal nor a subordinate of that individual. The Plan will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial adverse determination, without regard to whether the advice was relied upon in making the determination. You will be entitled to continue coverage pending the outcome of your appeal to the extent mandated by the ACA, which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. Before issuing a final determination based on a new or additional rationale, you shall be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the decision is required to be provided, as described below, to give you a reasonable opportunity to respond prior to that date.

- Decisions on appeals of Pre-Service claims must be made within 30 calendar days following receipt of the appeal of the adverse determination.

- Decisions on appeals of Urgent Care claims must be made within 72 hours following receipt of the appeal of the adverse determination. If your appeal relates to a medical claim involving Urgent Care, you will have the opportunity to expedite your appeal and the review procedure. In the case of Urgent Care, your appeal may be submitted orally or in writing, and necessary information, including the decision that is made with respect to the appeal, may be given by telephone, facsimile, or other similar expeditious method.

- Decisions on appeals of Post-Service claims must be made within 60 calendar days following receipt of your appeal of the adverse determination.

- Decisions on appeals of Concurrent Care claims are treated as Pre-Service claims, Urgent Care claims, or Post-Service claims, depending on the facts of the appeal and claim. If your appeal relates to a medical claim in which Concurrent Care has been reduced or terminated, you will not necessarily be given 180 days to submit an appeal depending on the facts of the appeal and claim and whether it is treated as a Pre-Service claim, Urgent Care claim, or Post-Service claim. Rather, based on the particular circumstances, you will be given a reasonable period of time to appeal before the benefit is reduced or terminated.

Extensions: You will be given notice of any such extension within the time periods described above. The notice will state the special circumstances involved and the date a decision is expected. If an extension is necessary because of your failure to submit information necessary to make a decision, the period for making the decision will be tolled from the date on which the notice of extension is sent until the date you respond to the request for additional information. If the information requested is not provided with the extension period, your claim will be decided without the necessary information.

Appeals Decision

The Plan Administrator will furnish you with a written decision providing the final determination of the claim. The Plan Administrator's review will take into account all comments, documents, records and other information related to the claim, regardless of whether such items were considered in the initial claim decision. The Plan Administrator's decision on review will be final and binding on you, your dependents and any other interested party. Your appeal notice will include:

- The specific reason or reasons for the appeal decision;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you have the right to request access to and copies of all relevant documents free of charge;
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA following an adverse determination on appeal;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process;
- In the case of a disability benefit claim, you will be notified of or given a statement of any internal rule, guideline, protocol, or other similar criteria that was relied upon in making the adverse determination and that a copy of such criteria will be provided free of charge upon request;
- In the case of a disability benefit claim or medical benefit claim that was based on a medical necessity or experimental treatment or similar exclusion or limit, you will be given either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- In the case of a medical benefit claim, information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the meaning of such codes);
- An explanation of how to request diagnosis and treatment codes (and their corresponding meanings);
- In the case of a medical benefit claim, available external review processes and the time limits; and
- In the case of a medical benefit claim, the contact information for any applicable consumer assistance office established under Section 2793 of the Public Health Service Act to assist you;
- In the case of a disability benefit claim, an explanation for any disagreement with and/or failure to follow the view regarding your disability of the Social Security Administration or any health care professionals who treated or evaluated you
- In the case of a disability benefit claim, a statement that the identity of any medical or vocational experts whose advice was obtained in connection with the denial, without regard to whether the advice was relied upon in making the denial determination, will be provided free of charge upon request
- In the case of a disability benefit claim, a statement that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records or other information relevant to the determination.

You may request and receive, free of charge, reasonable access to and copies of relevant documents, records, and other information in the Plan's possession. Relevant documents, records, and other information are those

that were relied on in making the benefit determination, were submitted/considered/generated in the course of making the benefit determination, demonstrate compliance with the Plan's or Benefit Option's administrative processes or safeguards, or in the case of a group health plan claim, constitute a statement of the Plan's or Benefit Option's policy or guideline regarding the benefits for your diagnosis, whether or not relied upon. In the case of a disability benefit claim, the denial notice will be culturally and linguistically appropriate and assistance will be available in any applicable non-English language, as required under ERISA.

External Review of Appeals Decision

Following a denial of a claim relating to you or your beneficiary's eligibility for benefits, you may also be entitled to initiate a claim for an external review under either state or federal external review procedures. This Plan intends to comply with the state and federal external review procedures, as applicable, and you will be provided with information describing your rights to file a request for an external review of a claim denial in accordance with these procedures, as applicable.

Finality of Review on Appeal

You will not be entitled to challenge the Plan Administrator's (or its designee's) determinations in judicial or administrative proceedings without first complying with these claims procedures. The decisions made pursuant to these procedures are final and binding on you, your beneficiaries, and any other party; provided, however, that if you have exhausted the claims procedures set forth in the Plan, you may seek review of your claim before a court of competent jurisdiction within twelve (12) months after the date your claim is finally denied. Notwithstanding any other provisions herein, any suit for benefits must be brought within twenty-four (24) months after the date the service or treatment was rendered.

BENEFIT OPTIONS

Medical Coverage

MEDICAL COVERAGE BENEFIT OPTION

Your medical coverage is a Benefit Option and key component of the Plan. This Benefit Option is a group health plan and pays benefits for the treatment of an illness or injury and offers many features, such as mental/behavioral health coverage, preventive health care coverage, well-baby care and prescription drug coverage. You should refer to Appendix A for more information about the available coverage levels for this Benefit Option that are offered by your employer or to Appendix B for coverage available to eligible retirees.

You may choose medical coverage for yourself and your eligible dependents under the following coverage levels:

- Single (or Employee Only)
- Dual (or Employee plus one other)
- Family (or Employee plus two or more others)

For questions and more information about your medical coverage, you may contact the Benefits Administrator at the contact information listed at the end of this SPD.

Certificates of Coverage

Your medical plan options are fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured medical plans and are incorporated into the terms of this SPD. The medical coverage under this Plan is described online at http://www.ucor.com/benefitsRMP.html. You may also request a paper copy of the medical certificate of coverage by contacting the Benefits Administrator or the Plan Administrator at the contact information listed at the end of this SPD.

Hospital Admissions for Maternity

The Newborns' and Mothers' Health Protection Act requires medical plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a cesarean section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate.

Post-Mastectomy Care

If you or a covered dependent is receiving benefits in connection with a mastectomy and you or your covered dependent elect breast reconstruction, the medical program options also cover, in a manner determined in consultation with the attending physician and the patient:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Coverage for prosthetic devices and reconstructive surgery is subject to the same copayments and deductibles as those established for other benefits under the medical program options.

Health Savings Accounts

A Health Savings Account ("HSA") is a special savings account you own, and contribute to, for paying current and future medical expenses. An HSA is not offered by this Plan, but this Plan does offer a high deductible health plan that allows you to be eligible to contribute to an HSA, if you so desire.

The contributions to an HSA can be made on an after-tax basis and are tax deductible on your individual tax returns. Also, HSA withdrawals are tax-free if used for qualified medical expenses. If you were to ever terminate employment, the money in your HSA that you do not use to reimburse yourself for qualified medical expenses can remain in the HSA no matter where or if you are employed since the HSA is portable. Unlike a flexible spending account, HSA accounts can grow on a tax deferred basis through investment earnings. Unused savings can remain available for later years (unlike a flexible spending account where unused annual savings are forfeited each year).

HSAs are owned by the individual (not the employer). The individual decides whether he or she should contribute, how much to use for medical expenses, how must to use for personal expenses (subject to income tax and an excise tax), which medical expenses to pay from the account, whether the pay for medical expenses from the account or save the account for future use, which bank/trustee will hold the HSA account, and what type of investments to grow the account.

Each of the following factors must be met to be eligible for an HSA:

- You need to be participating in a high deductible health plan (HDHP), which this Plan offers. The HDHP cannot provide "first dollar coverage" until the annual deductible is met, except for certain preventive care, and the HDHP cannot utilize co-pays;

- You cannot be covered by another other comprehensive medical insurance. This includes coverage such as your spouse/partner's health insurance. However, you can be covered by your own or your spouse/partner's dental, vision, individual accident, cancer, ICU (excluding specified health event and critical illness), employee assistance program, and long-term care insurance;

- You cannot be covered by Medicare;

- You cannot be covered by your own or your spouse/partner's comprehensive healthcare flexible spending account; and

- IRS rules limits benefits for domestic partners.

You are eligible to contribute up to the amount shown in the annual enrollment materials, which will not exceed the IRS contribution limit. These limits may change in future years. For participants age 55 and older, an additional $1,000 HSA "catch-up" contribution is allowed. If you have a spouse who is also age 55 and covered by the HDHP and not covered by any other healthcare plan, you may contribute the "catch-up" amount for them as well. Spouse "catch-up" contributions must be deposited into a separate HSA account that they have established. Limitations exist for domestic partners. Contributions must stop once an individual is enrolled in Medicare. If you fail to remain an eligible individual during the entire 12-month period, all contributions made prior to the date you qualified for a HDHP will be included in gross income and subject to a 20% excise tax in the year in which you cease to be an eligible individual. Contributions to the HSA in excess of the contribution limits must be withdrawn (and any prorated earnings) by the individual or be subject to additional excise taxes.

The ACA permits health plans to extend coverage to adult children up to the age of 26 regardless of student status, marital status, etc., but this extension of coverage has no application to the HSA. This means that if the adult dependent child is NOT a tax qualified dependent of the employee, healthcare expenses of the adult dependent child are not reimbursable from the employee's HSA, even if the adult child is covered under the HDHP. If the adult dependent child covered under the HDHP is not a tax qualified dependent of the employee, he/she can open an HSA independently and also contribute to the HSA the amounts allowable for family

coverage, and the adult dependent child can submit healthcare related expenses to his/her own HSA for reimbursement without penalty.

You may not contribute to both the healthcare flexible spending account and a HSA.

You are free to choose any HSA provider. You can locate HSA institutions at http://hsafinder.com. There may be fees involved with establishing an HSA with an HSA administrator.

More information about HSAs can be found in IRS Publication 969 titled, "Health Savings Accounts and Other Tax-Favored Health Plans" found at www.irs.gov. The summary of HSAs contained in this SPD is intended to be a brief overview and is not to be relied upon for detailed information for your specific situation.

Dental Coverage

DENTAL COVERAGE BENEFIT OPTION

This Plan promotes preventive dental care and also provides benefits for corrective services. You should refer to Appendix A for more information about the available coverage levels for this Benefit Option that are offered by your employer or Appendix B for more information about the coverage for eligible retirees.

Generally, the available coverage levels are listed below unless otherwise stated in Appendix A or Appendix B:

- Single (Employee Only)
- Dual (Employee plus one other)
- Family (Employee plus two or more others)

See "Participation" for more details on who is considered an eligible dependent and when you can enroll yourself and/or your eligible dependents for dental coverage.

For questions and more information about your dental coverage, you may contact the Benefits Administrator at the contact information listed at the end of this SPD.

Certificates of Coverage

Your dental plan options are fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured dental plans and are incorporated into the terms of this SPD. These documents are available from the applicable insurance carrier or by contacting the Benefits Administrator at the contact information listed at the end of this SPD. The dental coverage under this Plan is described online at http://www.ucor.com/benefitsRMP.html.

Vision Coverage

VISION COVERAGE BENEFIT OPTION

Through this Plan, vision coverage may be elected. Please refer to your enrollment materials for more information. You should also refer to Appendix A for more information about the available coverage levels for this Benefit Option that are offered by your employer or Appendix B for more information about the coverage for eligible retirees.

Generally, the available coverage levels are:

- Single (Employee Only)
- Dual (Employee plus one other)
- Family (Employee plus two or more others)

See "Participation" for more details on who is considered an eligible dependent and when you can enroll yourself and/or your eligible dependents for coverage.

For questions and more information about your vision coverage, you may contact the Benefits Administrator at the contact information listed at the end of this SPD.

Certificates of Coverage

Your vision plan options are fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured vision plans and are incorporated into the terms of this SPD. These documents are available from the applicable insurance carrier or by contacting the Benefits Administrator at the contact information listed at the end of this SPD. The vision coverage under this Plan is described online at http://www.ucor.com/benefitsRMP.html.

Long Term Disability Coverage

LONG TERM DISABILITY COVERAGE BENEFIT OPTION

If you become disabled from a non-work-related injury or illness and can't work, this Benefit Option helps you meet the challenge by offering long-term disability ("LTD").

You should refer to Appendix A for more information about this Benefit Option and whether it is offered by your employer or Appendix B for more information about the coverage for eligible retirees.

For questions and more information about your LTD coverage, you may contact the Benefits Administrator at the contact information listed at the end of this SPD.

Certificates of Coverage

This LTD coverage is fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured LTD coverage and are incorporated into the terms of this SPD. These documents are available from the applicable insurance carrier or by contacting the Benefits Administrator at the contact information listed at the end of this SPD. The long-term disability coverage under this Plan is described online at http://www.ucor.com/benefitsRMP.html.

Life Insurance Coverage

LIFE INSURANCE BENEFIT OPTIONS

The Plan's life insurance Benefit Options provide financial protection for you and your family in the event of a death. The life insurance program consists of: optional Basic Life Insurance, optional Supplemental Life Insurance, and optional Dependent Life Insurance.

- Basic Life Insurance (optional): Provides a benefit to your survivors in the event of your death.
- Optional Supplemental Life Insurance: Provides an additional benefit to your survivors in the event of your death.
- Optional Dependent Life Insurance: Provides a benefit to survivors in the event of the death of your spouse or child.

Tax Alert

If your Basic Life Insurance coverage does not exceed $50,000, the coverage is tax free to you. However, if your Basic Life Insurance coverage exceeds $50,000, you must include in your gross income the cost of the excess coverage that is paid by your employer. For this purpose, the cost is computed using a uniform premium table published by the Internal Revenue Service and is reported to you as imputed income on your Form W-2 ("C" in Box 12) and on your paycheck.

Evidence of Insurability

In some instances, you may be required to provide Evidence of Insurability ("EOI") for your elected life insurance coverages. This may require that you or your spouse pass a thorough physical examination. Coverage in excess of the amount subject to EOI will only become effective when the insurance company approves the EOI. This means that if you enroll for any life insurance that requires EOI at annual enrollment, coverage will become effective at the later of January 1 or the insurance company's approval of EOI. If you are on a leave of absence during annual enrollment, you will not be able to add or increase your life insurance coverage for yourself or any dependent during annual enrollment. Instead, you may make a new election to add or increase coverage during the 30-day period that begins on the day you return to work. You must contact the Benefits Center to make this change to your coverage. The election you make during this 30-day period will become effective on the later of the date you return to work or the date the insurer approves any required EOI.

Certificates of Coverage

Your life insurance options are fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured life insurance coverages and are incorporated into the terms of this SPD. These documents are available from the applicable insurance carrier or by contacting the Benefits Administrator at the contact information listed at the end of this SPD. The life insurance coverage under this Plan is described online at http://www.ucor.com/benefitsRMP.html.

Business Travel Accident Insurance Coverage

BUSINESS TRAVEL ACCIDENT INSURANCE COVERAGE BENEFIT OPTION

Business Travel Accident Insurance pays benefits in the event of accidental dismemberment or death while traveling on your employer's business if the loss occurs within 365 days of the accident. The travel must be away from your regular place of employment and at your employer's authorization, direction, and expense. Business travel may include travel or activities that are unrelated to business and which take place away from your residence or regular place of employment as long as such travel or activity coincides with your business travel and is limited to any consecutive seven-day period immediately prior to, during or immediately following your business travel. This does not include commuting to and from work.

Generally, eligible employees working for a Participating Employer who offers this Benefit Option are eligible for coverage under Business Travel Accident Insurance. Please refer to Appendix A to determine whether your employer offers this Benefit Option.

Certificates of Coverage

Your Business Travel Accident Insurance coverage is fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured Business Travel Accident Insurance coverages and are incorporated into the terms of this SPD. These documents are available from the applicable insurance carrier or by contacting the Benefits Administrator at the contact information listed at the end of this SPD. The business travel accident coverage under this Plan is described online at http://www.ucor.com/benefitsRMP.html.

Special Accident Insurance or Accidental Death and Dismemberment

SPECIAL ACCIDENT INSURANCE BENEFIT OPTION

This Plan offers Accidental Death and Dismemberment ("AD&D"). (Note that AD&D is sometimes also called "Special Accident Insurance.") AD&D Insurance is available for purchase and pays benefits for a death or dismemberment occurring within 365 days of, and resulting from, a covered accident while your coverage is in effect. You must elect AD&D coverage because enrollment is not automatic.

Generally, eligible employees working for a Participating Employer who offers this Benefit Option are eligible for coverage. Please refer to Appendix A to determine whether your employer offers this Benefit Option.

Certificates of Coverage

Your Special Accident Insurance options are fully insured by an insurance carrier. The separate Certificates of Coverage provided by the insurance carrier will govern the terms of the insured Special Accident Insurance coverages and are incorporated into the terms of this SPD. These documents are available from the applicable insurance carrier or by contacting the Benefits Administrator at the contact information listed at the end of this SPD. The AD&D coverage under this Plan is described online at http://www.ucor.com/benefitsRMP.html.

Employee Assistance Program Coverage

EMPLOYEE ASSISTANCE PROGRAM BENEFIT OPTION

The Employee Assistance Program ("EAP"), currently offered through Aetna's Resources for Living, provides a wide range of resources and information to help you balance your work and personal life. A simple toll-free call can connect you with a trained counselor who can provide assistance with a wide range of issues. The EAP is available to eligible employees at no cost.

You should refer to Appendix A for more information about this Benefit Option and whether it is offered by your employer.

Flexible Spending Accounts

FLEXIBLE SPENDING ACCOUNTS BENEFIT OPTIONS

UCOR offers its employees a way to pay certain health care and dependent care expenses for UCOR eligible active employees with pre-tax dollars through two types of Flexible Spending Accounts (the "FSAs") — a Health Care FSA and a Dependent Care FSA. This description of the FSAs only applies to those FSAs offered as a Benefit Option by UCOR to its employees. If you are an eligible active employee of UCOR, you should refer to Appendix A for more information about the Flexible Spending Accounts. If you are an employee of a different Participating Employer other than UCOR, you should contact your employer's human resources department to find out if your employer offers a FSA that is not under this Plan. The FSA coverage under this Plan is described online at http://www.ucor.com/benefitsRMP.html.

GENERAL INFORMATION

General Information

PLAN ADMINISTRATION

The Plan Administrator has the sole and complete discretionary authority to determine eligibility for Plan benefits and to construe the terms of the Plan, including the making of factual determinations. The Plan Administrator shall have the discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The decisions of the Plan Administrator shall be final and conclusive with respect to all questions relating to the Plan. If a Claims Administrator has the only review authority, the Claims Administrator's decision will be final and conclusive with respect to all questions.

The Plan Administrator may delegate certain of its Plan duties to other persons and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Plan. The Plan Administrator shall be entitled to rely on the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful.

The Plan Administrator may adopt uniform rules for the administration of the Plan from time to time, as it deems necessary or appropriate.

Amendment and Termination

UCOR, as the Plan Sponsor, and the Benefits and Investment Committee (BIC), as the Plan Administrator, reserve the sole discretionary right to modify, amend or terminate the Plan, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by the Amendment Committee, UCOR's Board of Directors, UCOR's Board of Managers, UCOR's President and Project Manager, or its designee.

UCOR's decision to change or terminate the Plan could result from:

- Changes in federal or state laws governing employee benefits;
- Changes in an insurance contract or policy involving an insurance company;
- Changes in a collective bargaining agreement; or
- Any other reason.

If the Plan is modified, amended or terminated, you will be notified of the effect of such change to your Plan benefits or coverage. However, the modification, amendment or termination may be effective before you are notified, to the extent permitted by law. Subject to the terms of any collective bargaining agreement or applicable law, no consent of any employee or any other person will be necessary for UCOR to modify, amend or terminate the Plan described in this SPD.

Representations Contrary to the Plan

No employee, director or officer of UCOR, or Participating Employer has the authority to alter, vary or modify the terms of the Plan except by means of a duly authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan are binding upon the Plan, the Plan Administrator or your employer.

No Assignment

To the extent permitted by law, and except as specified under the terms of the Plan, no benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt

to do so will be void. However, benefits under the Plan may be subject to a Qualified Medical Child Support Order (QMCSO).

Recovery of Benefit Payments Made by Mistake

You will be required to return to the Plan any benefits, or portion thereof, paid under the Plan by a mistake of fact or law. If you do not return benefits paid under the Plan by a mistake of fact or law, the Plan may offset your future benefits up to the amount you owe the Plan.

Recovery of Premiums in Arrears

You may be required to remit payment of premiums in arrears for time periods in which you received benefits under one or more Benefit Options in this Plan.

Responsibility for Tax Implication of Benefits

You will be responsible for the tax implications of and determination of imputed income with respect to any benefits you elect for eligible dependents who are not entitled to tax-free benefits under current federal law.

No Contract of Employment or Service

Your participation in the Plan does not assure you of continued employment with your employer or rights to benefits except as specified under the terms of the Plan. Nothing in the Plan or in this SPD confers any right of continued employment (or service, as applicable) to any employee or leased employee, as applicable.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan described in this SPD to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Plan shall continue in full force and effect.

Plan Funding

Benefits offered under the Plan are provided on either a self-insured basis by the Participating Employer or are fully insured through an insurance policy. Please see the “Plan Information” chart at the end of this section for more details on which third-party administrators and insurance companies provide services and benefits.

Applicable Law

The Plan described in this SPD shall be governed and construed in accordance with the laws of the state of Tennessee to the extent not preempted by the laws of the United States.

Governmental Benefits Exclusion

If services or benefits are reasonably available under any plan or program established by any government or under any plan or program in which any government participates (other than as an employer), benefits under the Plan are not payable for such services or benefits unless payment is legally required. In the case of any person who is not enrolled for all coverage for which he or she has become eligible under any such plan or program, services and benefits available shall nevertheless include all benefits to which he or she would be entitled if he or she were enrolled for such coverage. The term “any government” includes the federal, state, provincial or local government or any political subdivision thereof of the United States or any country. This provision is subject to any provision or regulation of such plan or program that requires that benefits be utilized before benefits are available thereunder.

General Information

Interpretive Authority

If the Plan document does not clearly dictate whether an expense is eligible under the Plan and/or what percentage of the eligible charge is covered, the Claims Administrator or insurer will make a determination and pay benefits accordingly. Except as provided above, if a question arises as to the interpretation of the terms of the Plan document, the Plan Administrator has discretionary authority to interpret, construe and apply the terms of the Plan document and to decide any such question, including but not limited to a question as to an eligible employee's eligibility to participate in the Plan.

Statement of ERISA Rights

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you are entitled to:

Receive Information About Your Plan and Benefits

- Examine without charge at the Plan Administrator's location all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as annual financial reports (Form 5500 Series).

- Obtain copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated SPD upon written request to the Plan Administrator (at the address below). The Plan Administrator may make a reasonable charge for the copies.

- Receive summaries of the Plan's annual financial reports. These summaries are prepared and distributed to Plan participants each year. The Plan Administrator is required by law to furnish each participant a copy of the summary annual report.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan regarding the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

General Information

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator (at the address below). If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL INFORMATION

Plan Sponsor	UCOR P.O. Box 4699 MS 7020, K-1007 Oak Ridge, TN 37831 865-576-9206 Employer Identification Number: 45-2178216
Plan Administrator	Benefits and Investment Committee P.O. Box 4699 MS 7020 Oak Ridge, TN 37831 865-576-9206 You may obtain a copy of any of the official legal documents from the Plan Administrator at the above address.
Agent for Legal Service	CT Corporation Systems 800 South Gay Street, Suite 2021 Knoxville, Tennessee 37929 Service of legal process may also be made on the Plan Administrator.
Plan Name **Plan Number** **Plan Year**	East Tennessee Technology Park Health and Welfare Benefit Plan Plan No. 510 January 1 – December 31
Plan Type	This Plan is an employee welfare benefit plan offering group health, disability, life, and accident coverages to eligible employees of Participating Employers.
Type of Administration	The type of administration depends upon the particular Benefit Option. If the Benefit Option is insured, then it is administered by the insurer. If the Benefit Option is self-insured, then it is administered by the Benefits Investment Committee as the Plan Administrator or its delegate.
Named Fiduciary (for Benefit Claims)	The Plan Administrator is hereby designated as the "named fiduciary," within the meaning of ERISA Section 402(a), with respect to the operation and administration of the Plan and is responsible, except to the extent provided hereof, for administering the Plan in accordance with its terms. For each of the insured Benefit Options, the insurance company is a "named fiduciary" with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.
Benefits Administrator (third party administrator delegated by the Plan Administrator)	Mercer Single Source 1 1-888-890-5631 www.hrbenefitsadvantage.com

Questions regarding your benefits or this SPD should be addressed to the Benefits Administrator.

PLAN INFORMATION

Benefit Option	Funding	Contact Information
Medical	Fully insured insurance contract with Aetna	Aetna 1-888-238-6203 www.aetna.com
Dental	Fully insured insurance contract with Cigna	Cigna 1-800-244-6224 www.mycigna.com
Vision	Fully insured insurance contract with Vision Service Plan Insurance Company	Vision Service Plan Insurance Company ("VSP") 1-800-877-7195 www.vsp.com
Flexible Spending Accounts	Self-Insured by UCOR	PayFlex 1-888-678-8242
COBRA Administrator	Not Applicable	Discovery Benefits 1-866-451-3399
Employee Assistance Program	Fully insured insurance contract with Aetna	Aetna Resources for Living™ 1-888-238-6232 www.resourcesforliving.com
Long-Term Disability	Fully insured insurance contract with Unum Life Insurance	Unum 1-800-421-0344 www.unum.com/claims
Basic Life Insurance **Supplemental Life Insurance** **Dependent Life Insurance**	Fully insured insurance contract with Securian Life Insurance	Securian 1-888-658-0193
AD&D Insurance	Fully insured insurance contract with Securian Life Insurance	Securian 1-888-658-0193
Business Travel Accident Insurance	Fully insured insurance contract with CIGNA Life Insurance Company of North America	Plan Administrator 1-865-576-9206

ETTP HEALTH AND WELFARE BENEFIT PLAN APPENDIX A

Four Rivers Nuclear Partnership, LLC Wastren Advantage, Inc.

APPENDIX A
Four Rivers Nuclear Partnership, LLC
Wastren Advantage, Inc.

PARTICIPATION ELIGIBILITY

Generally, you are eligible for health and welfare benefits if you are a full-time or part-time employee of Four Rivers Nuclear Partnership, LLC ("Four Rivers") or Wastren Advantage, Inc. ("WAI") and:

- You are a Grandfathered Employee employed in Covered Employment; or
- You are on long term disability with Four Rivers or WAI (as applicable)

The following definitions apply to the above eligibility criteria:

"Covered Employment" means regular and permanent, full- or part-time employment which is, with respect to (a) UCOR, work performed under the DOE Contract; (b) a Subcontractor, work performed in a Staffing Plan Position; (c) a New Prime Contractor, work performed under the New Contract for which the New Prime Contractor is the prime contractor as designated by the U.S. Department of Energy; and (d) a New Subcontractor, work performed under the New Contract by an employee who is a member of the class of employees with respect to whom the New Subcontractor has properly adopted the East Tennessee Technology Park Pension Plan for Grandfathered Employees (previously known as the Bechtel Jacobs Company LLC Pension Plan for Grandfathered Employees).

"Grandfathered Employee" has the meaning as set forth in the East Tennessee Technology Park Pension Plan for Grandfathered Employees.

YOUR BENEFIT OPTIONS

Following are ("Benefit Options") offered under this Plan by your employer as a Participating Employer from which you can choose if you meet certain eligibility criteria:

- Medical Coverage
- Dental Coverage
- Vision Coverage
- Life Insurance (Basic, Supplemental and Dependent)
- Long Term Disability Coverage

You are not eligible for Long Term Disability Coverage if you are a part-time employee.

Please refer to the specific discussion of each Benefit Option in the SPD and insurance documents for more information, including specific eligibility criteria, for each Benefit Option.

Medical

BENEFIT PLAN

Prepared Exclusively For
URS | CH2M Oak Ridge LLC (UCOR)

Open Access Managed Choice - Active Salaried Employees. Active Bargaining Unit Employees at Four Rivers Nuclear Partnership LLC, Wastren Advantage, Inc. (as a participating subcontractor under Four Rivers Nuclear Partnership, LLC) - Plan A

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℠

Table of Contents

*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface *(GR-9N-02-005-01 OH)*

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Group Policyholder:	URS | CH2M Oak Ridge LLC (UCOR)
Group Policy Number:	GP-720018
Effective Date:	January 1, 2018
Issue Date:	March 10, 2018
Booklet-Certificate Number:	5A

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage *(GR-9N-02-020-01 OH)*

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an accident, **injury** or **illness** that occurred, began or existed while coverage was in effect.

Please refer to the sections, "*Termination of Coverage (Extension of Benefits)*" and "*Continuation of Coverage*" for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

Coverage for You and Your Dependents *(GR-9N-02-020-01 OH)*

Health Expense Coverage *(GR-9N-02-020-01 OH)*

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet-Certificate* for more information about your coverage.

Treatment Outcomes of Covered Services *(GR-9N-02-020-01 OH)*

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Can Be Covered

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class", as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are considered an eligible employee as defined in the URS|CH2M Oak Ridge LLC (UCOR) Summary Plan Description. Aetna will rely on the representation of the employer as to a person's eligibility for coverage under the plan and as to any fact concerning such eligibility.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents *(GR-9N 29-010 01)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Dependent Children *(GR-9N-S-29-005-02-OH)*

To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Important Reminder
Keep in mind that you cannot receive coverage under this Plan as:

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

How and When to Enroll *(GR-9N 29-015-02)*

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Late Enrollment

If you do not enroll during the Initial Enrollment Period, or a subsequent annual enrollment period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next annual enrollment period. If, at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must return your completed enrollment form before the end of the next annual enrollment period.

However, you and your eligible dependents may not be considered **Late Enrollees** under the circumstances described in the "Special Enrollment Periods" section below.

Annual Enrollment *(GR-9N 29-015-HRPA OH)*

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Special Enrollment Periods *(GR-9N-29-015-05)*

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You or your dependents were covered under other **creditable coverage**; and
  - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other **creditable coverage**; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death;
  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - The employer's decision to stop offering the group health plan to the eligible class to which you belong;
  - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
  - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; or
  - You or your dependents have reached the lifetime maximum of another Plan for all benefits under that Plan.
- You or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

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

- 31 days of when other **creditable coverage** ends;
- within 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- within 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of termination of **creditable coverage** must be provided to **Aetna**. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents
You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to **Aetna** within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child
Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement;
- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment;
- Any coverage limitations for a preexisting condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage;

When You Receive a Qualified Child Support Order
A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a preexisting condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

When Your Coverage Begins *(GR-9N-29-025-01 OH)*

Your Effective Date of Coverage
If you have met all the eligibility requirements, your coverage takes effect on the later of:

- The date you are eligible for coverage; or
- The date your enrollment form is received; and

- The date your required contribution is received by **Aetna**.

If your completed enrollment information is not received within 31 days of your eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Important Notice:
You must pay the required contribution in full.

Your Dependent's Effective Date of Coverage *(GR-9N 29-025-02)*

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

Note: New dependents need to be reported to **Aetna** within 31 days because they may affect your contributions. If you do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Retired Employees

In lieu of corresponding rules which apply to employees:

- If any health expense benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when health expense insurance ends will also apply to you.

How Your Medical Plan Works

(GR-9N-S-08-05-01 OH)

Common Terms

Accessing Providers

Precertification

It is important that you have the information and useful resources to help you get the most out of your **Aetna** medical plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Important Notes

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this Booklet-Certificate as **covered expenses** that are **medically necessary**.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this Booklet-Certificate in a safe place for future reference.

Common Terms *(GR-9N-08-010-01)*

Many terms throughout this Booklet-Certificate are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your Open Access Plan *(GR-9N-08-020-01 OH)*

This Preferred Provider Organization Open Access plan provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your Open Access plan, you can directly access any **physician**, **hospital** or **other health care** provider (**network** or **out-of-network**) for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through **network providers** or **out-of-network providers**.

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

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

deductibles, **copayments**, and payment percentage will generally be lower when you use participating **network providers** and facilities.

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

Availability of Providers

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

Ongoing Reviews

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

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

How Your Open Access Plan Works *(GR-9N 08-030-02)*

The Primary Care Physician: *(GR-9N 08-030-02)*

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

You may search online for the most current list of participating providers in your area by using DocFind, **Aetna**'s online provider directory at www.aetna.com. You can choose a **PCP** based on geographic location, group practice, medical specialty, language spoken, or **hospital** affiliation. DocFind is updated several times a week. You may also request a printed copy of the provider directory through your policyholder or by contacting Member Services through e-mail or by calling the toll free number on your ID card.

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

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

Changing Your PCP

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

Specialists and Other Network Providers

You may directly access **specialists** and **other health care** professionals in the network for covered services and supplies under this Booklet-Certificate. Refer to the **Aetna provider directory** to locate network **specialists**, **providers** and **hospitals** in your area. Refer to the *Schedule of Benefits* section for benefit limitations and out-of-pocket costs applicable to your plan.

Important Note
ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care **providers**. If you have not received your ID card or if your card is lost or stolen, notify **Aetna** immediately and a new card will be issued.

Accessing Network Providers and Benefits *(GR-9N 08-040-01)*

- You may select a **PCP** or other direct access **network provider** from the **network provider directory** or by logging on to **Aetna**'s website at www.aetna.com. You can search **Aetna**'s online **directory**, DocFind, for names and locations of **physicians** and **other health care** providers and facilities. You can change your **PCP** at anytime.
- If a service you need is covered under the plan but not available from a **network provider** or **hospital** in your area, please contact Member Services by email or at the toll-free number on your ID card for assistance.
- Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there are no additional out-of-pocket costs to you as a result of a **network provider's** failure to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- You will not have to submit medical claims for treatment received from network health care professionals and facilities. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** or facility less any cost sharing required by you. You will be responsible for **deductibles**, **coinsurance** and **copayments**, if any.

  You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **copayments**, or **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits *(GR-9N 08-045-01)*

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

- **Network providers** have agreed to accept the **negotiated charge**. **Aetna** will reimburse you for a **covered expense,** incurred from a **network provider,** up to the **negotiated charge** and the maximum benefits under this Plan, less any cost sharing required by you such as **deductibles**, **copayments** and **payment percentage**. Your **payment percentage** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.
- You must satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- **Deductibles** and **payment percentage** are usually lower when you use **network providers** than when you use **out-of-network providers.**

- For certain types of services and supplies, you will be responsible for any **copayments** shown in the *Schedule of Benefits*.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Schedule of Benefits* section for information on what expenses do not apply. Refer to your *Schedule of Benefits* for the specific **maximum out-of-pocket limit** amounts that apply to your plan.

- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or Sch*edule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.
- You may be billed for any **deductible**, **copayment**, or **coinsurance** amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits *(GR-9N 08-045-01)*

You have the choice to access licensed **providers**, **hospitals** and facilities outside the network for covered benefits. Your out-of-pocket costs, such as **deductibles** and **coinsurance**, are usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan. **Aetna** will only pay up to the **recognized charge**.

- You select a health care provider or facility for covered benefits.
- **Precertification** is necessary for certain services. When you receive services from an **out-of-network provider**, you are responsible for obtaining the necessary **precertification** from **Aetna**. Your provider may **precertify** your treatment for you, however you should verify with **Aetna** prior to the procedure, that the provider has obtained **precertification** from **Aetna**. If your treatment is not **precertified**, the benefit payable may be significantly reduced. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- When you use **physicians** and **hospitals** that are not in the network you may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an **out-of-network provider**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required of you by your plan.
- If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Important Note
Failure to **precertify** will result in a reduction of benefits under this Booklet-Certificate. Please refer to the *Understanding Precertification* section of this Booklet-Certificate for information on how to **precertify**.

Cost Sharing for Out-of-Network Benefits *(GR-9N 08-045-01)*

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

- **Out-of-network providers** have not agreed to accept the **negotiated charge. Aetna** will reimburse you for a **covered expense,** incurred from an **out-of network provider**, up to the **recognized charge** and the maximum benefits under this Plan, less any cost-sharing required by you such as **deductibles** and **payment percentage.** The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from an **out-of-network provider**. Your **payment percentage** is based on the **recognized charge**. If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. Except for emergency services, **Aetna** will only pay up to the **recognized charge**.
- You must satisfy any applicable **deductibles** before the plan begins to pay benefits.
- **Deductibles** and **payment percentage** are usually higher when you use **out-of network providers** than when you use **network providers.**

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

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

Understanding Precertification *(GR-9N-08-060 01)*

Precertification

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

You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from **Aetna** for any services or supplies on the **precertification** list below. If you do not **precertify**, your benefits may be reduced, or the plan may not pay any benefits. The list of services requiring **precertification** follows on the next page.

Important Note
Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

The Precertification Process

Prior to being **hospitalized** or receiving certain other medical services or supplies there are certain **precertification** procedures that must be followed.

You are responsible for obtaining **precertification**. You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission or medical services and expenses prior to receiving any of the services or supplies that require **precertification** pursuant to this Booklet-Certificate in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call **Aetna** at the telephone number listed on your ID card. This call must be made:

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

Aetna will provide a written notification to you and your **physician** of the **precertification** decision. If your **precertified** expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

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

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna's** decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the Appeals Amendment included with this Booklet-Certificate.

Services and Supplies Which Require Precertification *(GR-9N 08-065 05 OH)*

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital**;
- **Stays** in a **skilled nursing facility**;
- **Stays** in a **rehabilitation facility**;
- **Stays** in a **hospice** facility;
- Outpatient **hospice care**;
- **Stays** in a **Residential Treatment Facility**;
- **Partial Hospitalization Programs**;
- **Home health care**;
- Private duty nursing care;
- Intensive Outpatient Programs;
- Applied Behavioral Analysis;
- Neuropsychological testing;
- Outpatient detoxification;
- Psychological testing;
- Transcranial magnetic stimulation (TMS).

How Failure to Precertify Affects Your Benefits *(GR-9N 08-070-01)*

A **precertification** benefit reduction will be applied to the benefits paid if you fail to obtain a required **precertification** prior to incurring medical expenses. This means **Aetna** will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary **precertification** from **Aetna** prior to receiving services from an **out-of-network provider**. Your provider may **precertify** your treatment for you; however you should verify with **Aetna** prior to the procedure, that the provider has obtained **precertification** from **Aetna**. If your treatment is not **precertified** by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered.

How Your Benefits are Affected

The chart below illustrates the effect on your benefits if necessary **precertification** is not obtained.

If **precertification** is:	then the expenses are:
▪ requested and approved by **Aetna**	▪ covered.
▪ requested and denied.	▪ not covered, may be appealed.
▪ not requested, but would have been covered if requested.	▪ covered after a **precertification** benefit reduction is applied.*
▪ not requested, would not have been covered if requested.	▪ not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your **precertification** requirement was not met will not count toward your **deductible, coinsurance limit** or **maximum out of pocket limit**.

*Refer to the *Schedule of Benefits* section for the amount of **precertification** benefit reduction that applies to your plan.

Emergency and Urgent Care *(GR-9N-27-005-01)*

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

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

In Case of a Medical Emergency

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

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **primary care physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **PCP** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **PCP** as soon as reasonably possible.

- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur. Please refer to the *Schedule of Benefits* for specific details about the plan. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the plan.

Coverage for Emergency Medical Conditions

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

Important Reminder
If you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the Plan.

In Case of an Urgent Condition *(GR-9N-27-010-01 OH)*

Call your **PCP** if you think you need urgent care. **Network providers** are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any **physician**, in- or out-of-network, for an **urgent care condition** if you cannot reach your **physician**.

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

Coverage for an Urgent Condition

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

Non-Urgent Care

If you seek care from an **urgent care provider** for a non-**urgent condition**, (one that does not meet the criteria above), the plan will not cover the expenses you incur unless otherwise specified under the Plan. Please refer to the *Schedule of Benefits* for specific plan details.

Important Reminder
If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-urgent care received at a hospital or an urgent care provider unless otherwise specified.

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

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

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

To keep your out-of-pocket costs lower, your follow-up care should be accessed through your **PCP**.

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

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

Requirements for Coverage *(GR-9N-09-005-01 OH)*

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

1. The service or supply or **prescription drug** must be covered by the plan. For a service or supply or **prescription drug** to be covered, it must:

   - Be included as a covered expense in this Booklet-Certificate;
   - Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet-Certificate for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.

2. The service or supply or **prescription drug** must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply or **prescription drug** must be **medically necessary**. To meet this requirement, the medical services, supply or **prescription drug** must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

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

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

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

What The Plan Covers

(GR-9N 11-005 OH)

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

Open Access Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

Preventive Care *(GR-9N 11-006 07 OH)*

This section on Preventive Care describes the **covered expenses** for services and supplies provided when you are well.

Important Notes:

1. The recommendations and guidelines of the:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
   - United States Preventive Services Task Force;
   - Health Resources and Services Administration; and
   - American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents;

   as referenced throughout this Preventive Care section may be updated periodically. This Plan is subject to updated recommendations or guidelines that are issued by these organizations beginning on the first day of the plan year, one year after the recommendation or guideline is issued.

2. If any diagnostic x-rays, lab, or other tests or procedures are ordered, or given, in connection with any of the Preventive Care benefits described below, those tests or procedures will not be covered as Preventive Care benefits. Those tests and procedures that are **covered expenses** will be subject to the cost-sharing that applies to those specific services under this Plan.

3. Gender-Specific *Preventive Care* Benefits — **covered expenses** include any recommended *Preventive Care* benefits described below that are determined by your provider to be **medically necessary**, regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. Refer to the Schedule of Benefits for information about cost-sharing and maximums that apply to Preventive Care benefits. **The Preventive Care benefits described below are not subject to cost-sharing.**

Two links to websites that discuss mandated preventive care benefits are attached here for your reference:

http://www.cdc.gov/vaccines/acip/index.html

http://www.healthcare.gov/center/regulations/prevention.html

Routine Physical Exams *(GR-9N 11-006 04 NG OH)*

Covered expenses include charges made by your **primary care physician (PCP)**, for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical 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 Guidelines for Children and Adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.
  - Screening for gestational diabetes for women.
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** check up.

Child Health Supervision Services

Covered expenses include charges for the periodic review of a child's physical and emotional status performed by a **physician** for a child from birth to age 9.

A periodic review is a review performed in accordance with the recommendations of the American Academy of Pediatrics and includes:

- A review and written record of the child's complete medical history.
- Taking measurements and blood pressure.
- Anticipatory guidance.
- Development and behavioral assessment.
- Hearing screening.
- Vision and lead toxicity screening and immunizations.
- One series of hereditary and metabolic tests performed at birth.
- Urinalysis and blood tests such as hematocrit and hemoglobin tests.
- Counseling and guidance of the child and the child's parents or guardians on the results of the physical exam.

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

- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit);
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Routine Cancer Screenings *(GR-9N 11-006 04 NG OH)*

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;

- Double contrast barium enemas (DCBE); and
- Colonoscopies (removal of polyps performed during a screening procedure is a **covered expense**).
- Lung cancer screening

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; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Although not included in the guidelines recommended by the United States Preventive Services Task Force or the guidelines supported by the Health Resources and Services Administration, the Plan also covers one baseline mammogram for a woman age 35 but less than age 40.

The total payment billed by a **provider** for a screening mammogram, including your cost sharing, cannot exceed 130% of the Medicare reimbursement amount for a screening mammogram. Only a baseline screening mammogram for women between the ages of 35 and 40 is subject to cost sharing. All other required screening mammograms are paid at 100% of billed charges.

Exclusions:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:
- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit).

Important Notes:
1. Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Preventive Care.
2. For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your **physician** or **Member Services** by logging onto the **Aetna** website www.aetna.com or calling the number on the back of your ID card.

Preventive Care Immunizations *(GR-9N 11-006 07 OH)*

Covered expenses include charges made by your **physician** or a facility for:
- immunizations for infectious diseases; and
- the materials for administration of immunizations;

that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Limitations:
Not covered under this Preventive Care benefit are charges incurred for:
- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit); and
- Immunizations that are not considered Preventive Care such as those required due to your employment or travel.

Well Woman Preventive Visits *(GR-9N 11-006 07 OH)*
Covered expenses include charges made by your **physician**, obstetrician, or gynecologist for:
- a routine well woman preventive exam office visit, including Pap smears/cytologic screening. A routine well woman preventive 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

- routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. **Covered expenses** include charges made by a **physician** and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

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; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Exclusions:
Unless specified above, not covered under this Preventive Care benefit are charges for:
- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit);
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Screening and Counseling Services *(GR-9N 11-006 07 OH)*

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

Obesity and/or Healthy Diet
Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
- Preventive counseling visits and/or risk factor reduction intervention;
- Nutritional counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

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

Use of Tobacco Products
Screening and counseling services to aid you to stop the use of tobacco products.

Coverage includes:
- Preventive counseling visits;
- Interventions;
- Treatment visits; and
- Class visits;

to aid you to stop the use of tobacco products.

Coverage includes the following, without any requirement for pre-authorization for treatment:
- 4 sessions of individual, group and phone counseling;
- 90 days of FDA-approved smoking cessation medications; and
- 2 quit attempts per year.

Tobacco product means a substance containing tobacco or nicotine including:
- Cigarettes;
- Cigars;
- Smoking tobacco;
- Snuff;
- Smokeless tobacco; and

- Candy-like products that contain tobacco.

Sexually Transmitted Infections
Covered expenses include the counseling services to help you prevent or reduce sexually transmitted infections.

Genetic Risks for Breast and Ovarian Cancer
Covered expenses include the counseling and evaluation services to help you assess your risk of breast and ovarian cancer susceptibility.

Benefits for the screening and counseling services above are subject to any visit maximums shown in your *Schedule of Benefits***.**

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for:
- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit).

Prenatal Care *(GR-9N 11-006 04 NG OH)*
Prenatal care will be covered as Preventive Care for services received by a pregnant female in a **physician's**, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check and fundal height).

Exclusions:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:
- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit); and
- Pregnancy expenses (other than prenatal care as described above).

Important Notes:
Refer to the Pregnancy Expenses and Exclusions sections of this Booklet-Certificate for more information on coverage for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services *(GR-9N 11-006 04 NG OH)*
Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breast-feeding by a certified lactation support provider. **Covered expenses** also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your Schedule of Benefits**.**

Breast Feeding Durable Medical Equipment
Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pump
Covered expenses include the following:
- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.
- The purchase of:

- An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
- A manual breast pump. A purchase will be covered once per pregnancy.

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

Breast Pump Supplies
Coverage is limited to only one breast pump purchase per pregnancy.

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

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Exclusions:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

• Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under a diagnostic testing benefit).

Family Planning Services - Female Contraceptives *(GR-9N 11-006 04 NG OH)*

For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **covered expenses** when provided in either a group or individual setting. They are subject to the contraceptive counseling services visit maximum shown in your Schedule of Benefits**.**

The following contraceptive methods are **covered expenses** under this Preventive Care benefit:

(GR-9N 11-006 04 NG OH)
Voluntary Sterilization
Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered expenses under this Preventive Care benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

Contraceptives *(GR-9N 11-006 04 NG OH)*
Contraceptives can be paid either under your medical plan or **pharmacy** plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive p**rescription drugs** and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit. For a list of the types of female contraceptives covered under this Plan, refer to the What the Pharmacy Plan Covers section and the Contraceptives benefit later in this Booklet-Certificate.

Important Note:
For a list of the types of female contraceptives covered under this Plan, refer to the section What the Pharmacy Plan Covers and the Contraceptives benefit later in this Booklet-Certificate.

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

- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test is payable under the diagnostic testing benefit);
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
- Services which are for the treatment of an identified **illness** or **injury**;
- Services that are not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices; and
- The reversal of voluntary sterilization procedures, including any related follow-up care.

Family Planning Services – Other *(GR-9N 11-006 04 NG OH)*

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

- Voluntary sterilization for males
- Voluntary termination of pregnancy

Exclusions:

Not covered under this **Family Planning Services – Other** benefit are:

- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your Policyholder; and
- Charges incurred for Family Planning Services-Other benefits while confined as an inpatient in a **hospital** or other facility.

Important Notes:

1. Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Family Planning Services - Other.
2. For more information, see the sections on Family Planning Services - Female Contraceptives, Pregnancy Expenses and Treatment of Infertility in this Booklet-Certificate.

Vision Care Services *(GR-9N 11-010-01 OH)*

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- ***Routine*** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 24 consecutive month period.

Limitations

Coverage is subject to any applicable Calendar Year **deductibles**, **copays** and **coinsurance** percentages shown in your *Schedule of Benefits.*

Hearing Exam *(GR-9N 11-015-01)*

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

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

The plan will not cover expenses for charges for more than one hearing exam for any 24-month period.

All **covered expenses** for the hearing exam are subject to any applicable **deductible**, **copay** and **coinsurance** shown in your *Schedule of Benefits*.

Physician Services *(GR 9N S 11-20 06)*

Physician Visits

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

Important Note:
All in-person office visits covered with a **behavioral health provider** are also covered if you use **telemedicine** instead.

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

Covered expenses also include:

- Immunizations for infectious disease;
- Allergy testing and allergy injections; and
- Charges made by the **physician** for supplies, x-rays, and tests provided by the **physician**.

Important Note:
For a description of the preventive care expenses covered under this Plan, refer to the *Preventive Care Benefits* section in this Booklet-Certificate.

Surgery

Covered expenses include charges made by a **physician** for:

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

Anesthetics

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

Important Note:

Certain procedures need to be **precertified** by **Aetna**. Refer to the *How the Plan Works* section of this Booklet-Certificate for more information about **precertification**.

Alternatives to Physician Office Visits *(GR-9N 11-020 02)*

Walk-In Clinic Visits

Covered expenses include charges made by **walk-in clinics** for:
Unscheduled, non-emergency illnesses and injuries; and the administration of certain immunizations administered within the scope of the clinic's license.

E-Visits
Covered expenses include charges made by your **physician** for a routine, non-emergency, medical consultation. You must make your **E-visit** through an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.Aetna.com or by calling the number on your identification card.

Hospital Expenses *(GR-9N-S-11-030-05 OH)*

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

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

Room and board charges also include:

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

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

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

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

Outpatient Hospital Expenses *(GR-9N-S-11-030-05 OH)*
Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

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

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

Hospital admissions need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

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

Refer to the *Schedule of Benefits* for details about any applicable **deductible**, **copay** and **coinsurance** and maximum benefit limits.

Coverage for Emergency Medical Conditions *(GR-9N-11-035 01 OH)*

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

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

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

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

Coverage for Urgent Conditions *(GR-9N-11-035 01 OH)*

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

Your coverage includes:

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

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

If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*.

Alternatives to Hospital Stays *(GR-9N-11-040-01 OH)*

Outpatient Surgery and Physician Surgical Services

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

- A **physician** or **dentist** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

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

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

The following outpatient surgery expenses are covered:

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

Limitations
Not covered under this plan are charges made for:

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

Birthing Center *(GR-9N-11-045 01 OH)*
Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.
- Longer stays require precertification.

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

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Pregnancy Related Expenses* for information about other **covered expenses** related to maternity care.

Home Health Care *(GR-9N-11-050-05 OH)*
Covered expenses include charges for home health care services when ordered by a **physician** as part of a home health plan and provided you are:

- Transitioning from a **hospital** or other inpatient facility, and the services are in lieu of a continued inpatient **stay**; or
- **Homebound**

Covered expenses include only the following:

- **Skilled nursing services** that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a **hospital** or **skilled nursing facility** after an inpatient **stay**, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous **skilled nursing services**. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.

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

In figuring the Calendar Year Maximum Visits, each visit of a:

- Nurse or Therapist, up to 4 hours is one visit.

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

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

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

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

Note: Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed in the Short Term Rehabilitation Therapies section of the *Schedule of Benefits*.

Limitations

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

- Services or supplies that are not a part of the **Home Health Care Plan**.
- Services of a person who usually lives with you, or who is a member of your or your spouse's family.
- Services of a certified or licensed social worker.
- Services for physical, occupational and speech therapy. Refer to Short Term Rehabilitation Therapies section for coverage information.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are **custodial care**.

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

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

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

Skilled Nursing Care *(GR-9N S-11-065-01 OH)*

Covered expenses include charges by an **R.N.**, **L.P.N.**, or nursing agency for outpatient skilled nursing care.

This is care by a visiting **R.N.** or **L.P.N.** to perform specific skilled nursing tasks.

Covered expenses also include private duty nursing provided by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing care and visiting nursing care is not adequate. However, **covered expenses** will not include private duty nursing for any shifts during a Calendar Year in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Limitations

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

- Nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a **R.N.** or **L.P.N.** to administer medicines.

Skilled Nursing Facility *(GR-9N-11-060-01 OH)*

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

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

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable **skilled nursing facility** maximums.

Admissions to a **skilled nursing facility** must be **precertified** by **Aetna**. Refer to *How Your Medical Plan Works* for details about **precertification**.

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

- Charges made for the treatment of:
  - Drug addiction;
  - Alcoholism;
  - Senility;
  - Mental retardation; or
  - Any other mental illness; and
- Daily **room and board** charges over the **semi-private rate**.

Hospice Care *(GR-9N S-11-070-01 OH)*
Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses
The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

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

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

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

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

- Medical supplies;
- **Prescription drugs**;
- Psychological counseling; and
- Dietary counseling.

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

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

Important Reminders
Refer to the *Schedule of Benefits* for details about any applicable **hospice care** maximums.

Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

Other Covered Health Care Expenses *(GR-9N-11-080-01 OH)*

Acupuncture
The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed:

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

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.

Ambulance Service *(GR-9N-11-080-01 OH)*
Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance
Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

Air or Water Ambulance

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

- Ground **ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **hospital** to another **hospital**; when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**; and the two conditions above are met.

Exclusions

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

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service; or
- By fixed wing air ambulance from an **out-of-network provider**.

Autism Spectrum Disorders *(GR-9N-11-171-06 OH)*

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Covered expenses include charges made by a **physician** or **behavioral health provider** for services and supplies for the screening, diagnosis, prescription drugs and treatment of Autism Spectrum Disorder. The services and supplies must be prescribed or ordered by a **physician** or a **behavioral health provider**, including a pediatrician or a psychologist trained in Autism Spectrum Disorder, and is as part of a treatment plan.

Coverage also includes outpatient physical rehabilitation services, including physical, speech and occupational therapies, and clinical therapeutic interventions. Clinical therapeutic interventions are defined as therapies supported by empirical evidence that include, but are not limited to, applied behavioral analysis, provided by or under the supervision of a professional that is licensed, certified, or registered by an appropriate agency of Ohio to perform the services in accordance with a treatment plan. Please see your schedule of benefits for any benefit limitations.

Coverage also includes clinical therapeutic interventions such as Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that:

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

Exclusions:

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

- Educational services for behavioral disorders are listed as not covered in the *Medical Plan Exclusions and Limitations* section of the Policy.

Important Note
Covered expenses are contingent on getting **precertification** described in the **precertification** process in this Booklet-Certificate.

Diagnostic and Preoperative Testing *(GR-9N-11-085-01)*

Diagnostic Complex Imaging Expenses

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

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging including positron emission tomography (PET) scans; and
- Any other outpatient diagnostic imaging service where the **recognized charge** exceeds $500.

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

Limitations

This Plan does not cover diagnostic complex imaging expenses under this part of this Plan if such imaging expenses are covered under any other part of this Plan.

Outpatient Diagnostic Lab Work and Radiological Services

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

Important Note
Refer to the *Schedule of Benefits* for details about any **deductible, coinsurance** or benefit maximum that applies to outpatient diagnostic testing, lab and radiological services.

Outpatient Preoperative Testing

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

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**;
- Not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.
- Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.
- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will ***not*** be covered.

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

Limitations

This Plan does not cover diagnostic complex imaging expenses under this part of this Plan if such imaging expenses are covered under any other part of this Plan.

Durable Medical and Surgical Equipment (DME) *(GR-9N S-11-090-01 OH)*

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

The initial purchase of **DME** if:

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

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

Replacement of purchased equipment if:

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

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

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

Important Reminder
Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible**, **coinsurance** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

Clinical Trials *(GR-9N 11-095 04 NG OH)*

Clinical Trial Therapies (Experimental or Investigational)

Covered benefits include "routine patient costs" furnished to a member in connection with participation in an "approved clinical trial" 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:

(A) Federally funded trials

The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(i) The National Institutes of Health.

(ii) The Centers for Disease Control and Prevention.

(iii) The Agency for Health Care Research and Quality.

(iv) The Centers for Medicare & Medicaid Services.

(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(vii) Any of the following:

(I) The Department of Veterans Affairs.

(II) The Department of Defense.

(III) The Department of Energy

if the study or investigation has been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines--

(a) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(b) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In addition, **covered benefits** includes "routine patient care" costs furnished to a member participating in any stage of an "eligible cancer clinical trial" as those terms are defined in the Ohio Revised Code, Section 3923.80 and below, if this plan would cover the routine patient care costs of members not participating in the eligible cancer clinical trial.

Covered benefits also include:

- 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; and
- The experimental intervention itself (except Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

"Eligible cancer clinical trials" means a cancer clinical trial that meets all of the following criteria:

- A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
- The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- The trial does one of the following:
  - Tests how to administer a health care service, item, or drug for the treatment of cancer;
  - Tests responses to a health care service, item, or drug for the treatment of cancer;

- Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
- Studies new uses of a health care service, item, or drug for the treatment of cancer.
- The trial is approved by one of the following entities:
  - The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services;
  - The United States food and drug administration;
  - The United States department of defense;
  - The United States department of veterans' affairs.

In addition, **covered benefits** include charges made for **experimental or investigational** drugs, devices, treatments or procedures under an "approved clinical trial" or an "eligible cancer clinical trial" other than

- "routine patient costs" furnished in connection with an "approved clinical trial," and
- "routine patient care costs" furnished in connection with an "eligible cancer clinical trial,"

provided **all** of the following conditions are met:

- The clinical trial is appropriate for the member's cancer or other life-threatening disease or condition, based on either one of the following:
  - The referring health care professional is a participating health care provider and has concluded that the member's participation in the trial would be appropriate, or
  - The member provides medical and scientific information establishing in Aetna's reasonable judgment that the member's participation in the clinical trial would be appropriate;
- You are treated in accordance with the clinical trial protocol; and
- The sponsors of the clinical trial charges all participants in the clinical trial for the drug, device, treatment or procedure.

You are subject to all of the terms, conditions, provisions, limitations and exclusions of this plan including, but not limited to, **precertification** requirements.

These conditions do not apply to cancer clinical trials.

Exclusions:
Not covered are:
- These clinical trial therapies:
  - 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; and
  - The experimental intervention itself (except Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

Important Notes:
1. Refer to the Schedule of Benefits for details about cost sharing and any benefit maximums that apply to the Clinical Trial benefit. 2. These Clinical Trial benefits are subject to all of the terms; conditions; provisions; limitations; and exclusions of this Plan including, but not limited to, any **precertification** and **referral** requirements.

Pregnancy Related Expenses *(GR-9N 11-100-01-OH)*

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

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

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

Covered expenses also include the charges for post discharge follow-up care for a mother and her newborn ordered and supervised by a **physician**. Services related to maternity follow-up care are covered whether such services are provided in a medical setting or in the home.

If the mother is discharged earlier than the minimum lengths of stay indicated above, all follow-up care received within 72 hours after discharge is covered without regard to medical necessity.

If the mother receives at least the minimum number of hours of inpatient care shown above, follow-up care that is not medically necessary will not be covered.

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

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

Prosthetic Devices *(GR-9N 11-110-01)*

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

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;

- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

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

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

Hearing Aids *(GR-9N-26-005-01)*

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

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

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

Benefits After Termination of Coverage

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

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

Reconstructive or Cosmetic Surgery and Supplies

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

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

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

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

Reconstructive Breast Surgery

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

Important Notice
A benefit maximum may apply to reconstructive or **cosmetic** surgery services. Please refer to the *Schedule of Benefits*.

Short-Term Rehabilitation Therapy Services *(GR-9N 11-120 09 OH)*

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

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

Charges for the following short term rehabilitation expenses are covered:

Cardiac Rehabilitation Benefits

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Certificate**.

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

Pulmonary Rehabilitation Benefits

- Pulmonary rehabilitation benefits are covered as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

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

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet-Certificate**.

- Physical therapy (including spinal manipulation) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries** , provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

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

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in your home, if you are **homebound**.

Important Reminder
Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.

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

- Therapies for the treatment of congenital defects amenable to surgical repair (such as cleft lip/palate);
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or **hospice facility** except as stated above;
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Specialized Care *(GR-9N 11-135-06-OH)*

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

Radiation Therapy Benefits
Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits
Covered expenses include infusion therapy received from an outpatient setting including but not limited to:

- A free-standing outpatient facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

The list of preferred infusion locations can be found by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

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

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

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

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

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

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

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

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

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable **deductible**, **coinsurance** or benefit maximum that apply.

Specialty Care Prescription Drugs

Covered expenses include **specialty care 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 care prescription drug** list as covered under this certificate.

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

Treatment of Infertility *(GR-9N 11-135-06-OH)*

Basic Infertility Expenses

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Comprehensive Infertility Expenses

To be an eligible covered female for benefits you must be covered under this *Booklet-Certificate* as an employee, or be a covered dependent who is the employee's spouse.

Even though not incurred for treatment of an **illness** or **injury**, **covered expenses** will include expenses incurred by an eligible covered female for **infertility** if all of the following tests are met:

- A condition that is a demonstrated cause of **infertility** which has been recognized by a gynecologist, or an infertility specialist, and your **physician** who diagnosed you as **infertile**, and it has been documented in your medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than, 19 miU on day 3 of the menstrual cycle.
- The **infertility** is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this *Booklet-Certificate*.

Comprehensive Infertility Services Benefits *(GR-9N 11-135-01-OH)*

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an infertility specialist upon pre-authorization by **Aetna**, subject to all the exclusions and limitations of this *Booklet-Certificate*:

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

Exclusions and Limitations

Unless otherwise specified above, the following charges will not be payable as **covered expenses** under this *Booklet-Certificate*:

- **Infertility** services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of sterilization surgery;
- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits;
- Injectable **infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
- Any services or supplies provided without pre-authorization from Aetna's infertility case management unit;
- **Infertility** Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not **infertile**;

- Any ART procedure or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); or
- Any charges associated with care required to obtain ART services (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); and any charges associated with obtaining sperm for any ART procedures.

Important Note
Treatment of **Infertility** must be pre-authorized by **Aetna**. Treatment received without pre-authorization will not be covered. You will be responsible for full payment of the services.

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

Transplant Services *(GR-9N-11-160-01-OH)*

Covered expenses include charges incurred during a Transplant Occurrence. Once it has been determined that you or one of your dependents may require an organ transplant, you or your **physician** should call **Aetna** to obtain the necessary precertification. Organ means solid organ; stem cell; bone marrow; and tissue.

Network of Transplant Specialist Facilities

Benefits may vary if an **Institute of Excellence™ (IOE)** facility or non-**IOE** or **out-of-network** provider is used. Through the **IOE** network, you will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

The network level of benefits is paid only for a treatment received at a facility designated by the plan as an **IOE** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from an **IOE** facility will be considered in-network care expenses.

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

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent that it is not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech, and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parent, sibling, or child.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the 4 phases of transplant care described below. Expenses incurred for 1 transplant during these 4 phases of care will be considered 1 Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The 4 phases of 1 Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the Plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous Blood/Bone Marrow transplant followed by Allogenic Blood/Bone Marrow transplant (when not part of a tandem transplant);
- Allogenic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g. a liver transplant with subsequent heart transplant).

Limitations

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

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not a covered person;
- Home infusion therapy after the Transplant Occurrence.

- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing **illness**.
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing **illness**;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

Important Reminders
To ensure coverage, all transplant procedures need to be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for details about **precertification**.

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

Treatment of Mental Disorders and Substance Abuse *(GR-9N-11-172-01)*

Treatment of Mental Disorders *(GR-9N-11-172-01)*

Covered expenses include charges made by a **hospital**, **psychiatric hospital**, **residential treatment facility** or **behavioral health provider** for the treatment of **mental disorders** as follows**:**

- Inpatient **room and board** at the **semi-private room rate,** and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:

  - Office Visits to a **physician** (such as a **psychiatrist)**, psychologist, social worker, or licensed professional counselor, as well as other health professionals. Includes **telemedicine** consultation.

  - Individual, group and family therapies for the treatment of mental disorders.

  - Other outpatient **mental disorder** treatment such as:
    - **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment.
    - Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program 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 because of **illness** or **injury**.
      - Your **physician** orders them.
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home.
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
    - Mental health injectables
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation.

Important Notes:

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

Inpatient treatment and certain outpatient treatments must be **precertified** by **Aetna**. Refer to the *Understanding Your Aetna Medical Expense Insurance* section for details.

Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums and **coinsurance limits** that may apply to your **mental disorder** benefits.

Treatment of Substance Abuse *(GR-9N-11-172-01)*

Covered expenses include charges made by a **hospital**, **psychiatric hospital**, **residential treatment facility** or **behavioral health provider** for the treatment of **substance abuse** as follows:

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

  As used here, "medical complications" include, but are not limited to, 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 (**such as a **psychiatrist)**, psychologist, social worker, or licensed professional counselor, as well as other health care professionals (includes **telemedicine** consultation).

  - Individual, group and family therapies for the treatment of substance abuse.

  - Other outpatient **substance abuse** treatment such as:
    - Outpatient **detoxification**.
    - **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment.
    - Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program under the direction of a **physician**.
    - Ambulatory **detoxification** – Outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications.
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound because of **illness** or **injury**.
      - Your **physician** orders them.
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home.
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
    - Treatment of withdrawal symptoms.
    - Substance use disorder injectables.
    - 23 hour observation.

Important Notes:

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

Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums and **coinsurance limits** that may apply to your **substance abuse** benefits.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) *(GR-9N 11-180-01)*

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

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

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

- Treat a fracture, dislocation, or wound.
- Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when ***not*** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

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

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

(a) Natural teeth damaged, lost, or removed; or
(b) Other body tissues of the mouth fractured or cut

due to **injury**.

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

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

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Medical Plan Exclusions *(GR-9N 28-15 16)*

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section.

Important Note:
You have medical and **prescription drug** insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific **prescription drug** coverage. Those additional exclusions are listed separately at the end of this section, if applicable.

Charges made for the following are not covered except to the extent listed under the What The Plan Covers section or by amendment attached to this Booklet-Certificate.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

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

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

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under this Booklet-Certificate, or such drugs or supplies are unavailable or illegal in the United States, or the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

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

Behavioral Health Services:

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 *What the Plan Covers- Preventive Care* section
- Pathological gambling, kleptomania, pyromania
- School and/or education services, including special education, remedial education, wilderness treatment programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mental retardation in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet-Certificate.

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

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

Charges for a service or supply furnished by an **out-of-network provider** in excess of the **recognized charge**.

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

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

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

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

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter the shape or appearance of the body except as specifically described under the *What the Plan Covers* section including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices.

This cosmetic services exclusion does not apply to surgery after an accidental **injury** when performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically described in the *What the Plan Covers* section.

Court ordered services, including those required as a condition of parole or release.

Custodial Care.

Dental Services: Except as specifically described in the *What the Plan Covers* section, any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of **injuries** and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- Services of **dentists**, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth;
- Non-surgical treatments to alter bite or the alignment or operation of the jaw, except as specifically described in the *What the Plan Covers* section, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

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

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

Drugs, medications and supplies (except as specifically described in the *What the Plan Covers* section) including:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any **prescription drug** purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to travel or work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-**covered expenses**;
- Performance enhancing steroids;
- Implantable drugs and associated devices;
- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drug**s;
- Self-injectable **prescription drug**s and medications;
- Any **prescription drug**s, injectables, or medications or supplies provided by the Policyholder or through a third party vendor contract with the Policyholder;
- Any expenses for prescription drugs, and supplies covered under an **Aetna** managed prescription plan will not be covered under this medical expense plan; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Early intensive behavioral interventions:

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

Educational services:

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

Examinations, except as described in the *What the Plan Covers* section and required under the federal preventive care services:

- Any health examinations required:
  - By a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - By any law of a government;
  - For securing insurance, school admissions or professional or other licenses;
  - To travel;
  - To attend a school, camp, or sporting event or participate in a sport or other recreational activity.

- Any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;

- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

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

Foot care: Except as specifically covered in the *What the Plan Covers* section -- any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:

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

Growth/Height: Any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones.

Hearing: Except as specifically covered in the *What the Plan Covers* section

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility;
- Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

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

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

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries, except for **emergency medical conditions**.

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

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;

- Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, 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;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- Any charges associated with care required to obtain ART Services (e.g., office, **hospital**, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care.

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

Miscellaneous charges for services or supplies:

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

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

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

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including:

- Telephone, television, internet, barber or beauty service or other guest services;
- Housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and
- Travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

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

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, 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;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

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

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

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

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including:

- Telephone, television, internet, barber or beauty service or other guest services;
- Housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and
- Travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

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

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, 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;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

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

Miscellaneous charges for services or supplies including:

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

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

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

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including:

- Telephone, television, internet, barber or beauty service or other guest services;
- Housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and
- Travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services. Skilled nursing care is covered as specifically described in the *What the Plan Covers* section in accordance with a home health treatment plan approved by **Aetna**.

Prosthetics or prosthetic devices unless specifically covered under *What the Plan Covers* Section.

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

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

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

Sexual dysfunction/enhancement: except as specifically described in the *What the Plan Covers* section, any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

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

Tobacco Use: except as specifically described in the *What the Plan Covers* section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet-Certificate.

Services that are not covered under this Booklet-Certificate.

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

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

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

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

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

Telemedicine:

- Services given by **providers** that are not contracted with **Aetna** as **telemedicine providers**
- Services given when you are not present at the same time as the **provider**
- Services including:
  - Telephone calls for behavioral health services
  - **Telemedicine** kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered except as specifically described in the *What the Plan Covers* section. Examples of non-covered diagnoses include Pervasive Developmental Disorders, Down syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Therapies and tests: Any of the following treatments or procedures:

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

Transplant Related Services- except as specifically described in the *What the Plan Covers* section, the transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**.

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in *What the Plan Covers* section.

Vision-related services and supplies, except as described in the *What the Plan Covers* section, not covered under this section:

- Anti-reflective coatings;
- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Tinting of eyeglass lenses;
- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams to diagnose or treat an **illness** or **injury** (This is covered under your medical benefits.);
- 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;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.

Weight: except as specifically described in the *What the Plan Covers* section, including preventive services for obesity screening and weight management interventions, a treatment or drug intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions, including but not limited to:

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

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

Your Pharmacy Benefit *(GR-9N-12-005-06 OH)*

How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your **prescription drug** plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access **network pharmacies** and procedures you need to follow;
- What **prescription drug** expenses are covered and what limits may apply;
- What **prescription drug** expenses are not covered by the plan;
- How you share the cost of your covered **prescription drug** expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

Important Notes:

- Unless otherwise indicated, "you" refers to you and your covered dependents. You can refer to the *Eligibility* section for a complete definition of "you".
- The plan pays benefits only for **prescription drug** expenses described in this *Booklet-Certificate* as **covered expenses** that are **medically necessary**.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive **prescription drugs** that are not or might not be covered benefits under this **prescription drug** plan.
- Store this *Booklet-Certificate* in a safe place for future reference.

(GR-9N 12-005 01 OH)

Notice

The plan does not cover all **prescription drugs**, medications and supplies. Refer to the *Prescription Drug Limitations* section and the *Exclusions* section of this *Booklet-Certificate*.

- **Covered expenses** are subject to cost sharing requirements as described in the *Cost Sharing* section and the *Schedule of Benefits*.
- **Injectable drugs** and **specialty care drugs** will only be covered when obtained through a **specialty pharmacy network** pharmacy.

Getting Started: Common Terms

You will find the terms below used throughout this Booklet-Certificate. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary*.

Brand-Named Prescription Drug is a **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by **Aetna**.

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

Network pharmacy is a description of a **retail, mail order or specialty pharmacy** that has entered into a contractual agreement with **Aetna, an affiliate, or a third party vendor,** for the provision of **covered services** to you and your covered dependents. The appropriate **pharmacy** type may also be substituted for the word **pharmacy**. (E.g. **network retail pharmacy, network mail order pharmacy or specialty pharmacy network**).

Non-Preferred Drug (Non-Formulary) is a **brand-named prescription drug** or **generic prescription drug** that does not appear on the **preferred drug guide**.

Out-of-network pharmacy is a description of a **pharmacy** that has not contracted with **Aetna, an affiliate, or a third party vendor,** and does not participate in the pharmacy network.

Preferred Drug (Formulary) is a **brand-named prescription drug** or **generic prescription drug** that appears on the **preferred drug guide**.

Preferred Drug Guide is a listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand-named prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and changes by **Aetna**. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.aetna.com/formulary.

Prescription Drug is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

Provider is any recognized health care professional, pharmacy or facility providing services with the scope of their license.

Self-injectable Drug(s). Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of **Self-injectable Drugs**, designated by **Aetna** as eligible for **coverage** shall be available upon request or may be accessed at the **Aetna** website, at www.aetna.com. The list is subject to change by **Aetna** or an affiliate.

Accessing Pharmacies and Benefits *(GR-9N 12-015 01 OH)*

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. Aetna has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network** and **out-of-network benefits**. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty pharmacies.

You also have the choice to access Ohio licensed **pharmacies** outside the **network** for **covered expenses**.

Accessing Network Pharmacies and Benefits

You may select a **network pharmacy** from Aetna's on-line provider directory which can be found at www.aetna.com. You can search **Aetna**'s online directory, DocFind, for names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area, call Member Services at the number on your ID card.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for **network pharmacy benefits**. The **network pharmacy** will calculate your claim online. You will pay any **deductible**, **copaymen**t or **coinsurance** directly to the **network pharmacy**. You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

Emergency Prescriptions

When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain **network pharmacy** benefits by filling your **prescription** at any **network pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan's cost sharing amount.

If you access an **out-of-network pharmacy** you will pay the full cost of the **prescription** and will need to file a claim for reimbursement. You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less your plan's cost sharing for **network pharmacy** benefits.

Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the provider contract.

Cost Sharing for Network Benefits

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

- You will need to satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The **copayment** is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.
- After you satisfy any applicable **deductible** and pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** amount is determined by applying the applicable **coinsurance** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

When You Use an Out-of-Network Pharmacy *(GR-9N-12-020-01 OH) (GR-9N 13-005 01 OH)*

You can directly access an **out-of-network pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-network **pharmacy**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

Cost Sharing for Out-of-Network Benefits *(GR-9N-12-020-01 OH)*

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

- You will need to satisfy any applicable calendar year **deductibles** before the plan will begin to pay benefits.

- After you satisfy any applicable year **deductible(s)**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** share is based on the **recognized charge**. If the **out-of-network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

Pharmacy Benefit *(GR-9N 13-006 04)*

What the Plan Covers

The plan covers charges for **medically necessary** outpatient **prescription drugs** for the treatment of an **illness** or **injury**, subject to the *Prescription Drug Limitations* section below and the *Exclusions* section of the *Booklet-Certificate*. **Prescriptions** must be written by a **prescriber** licensed to prescribe federal legend **prescription drugs**.

Your prescription drug benefit coverage is based on **Aetna's preferred drug guide**. Your out-of-pocket expenses may be higher if your **physician** prescribes a covered **prescription drug** not appearing on the **preferred drug guide**.

Preferred generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. You may minimize your out-of-pocket expenses by selecting a **generic prescription drug** when available.

Coverage of **prescription drugs** may, in **Aetna**'s sole discretion, be subject to **precertification**, or other **Aetna** requirements or limitations. **Prescription drugs** covered by this plan are subject to drug utilization review by **Aetna** and/or your **provider** and/or **your network pharmacy**.

The plan does not cover charges for **prescription drugs** listed on **formulary exclusions list**. Drugs on the **formulary exclusions list** are excluded from coverage unless a medical exception for coverage is obtained. If it is **medically necessary** for you to use a **prescription drug** on the **formulary exclusions list**, the **prescriber** who prescribed the drug must request coverage as a medical exception. Refer to the Medical Exceptions description under precertification for information on how your **prescriber** can obtain a medical exception for your prescription if necessary.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

Retail Pharmacy Benefits *(GR-9N 13-008 03 OH)*

Outpatient **prescription drugs** are covered when dispensed by a retail network **pharmacy** or a retail **out-of-network pharmacy**. When you go to a retail **pharmacy**, each **prescription** is limited to a maximum 30 day supply when filled at a retail **pharmacy**. **Prescriptions** for more than a 30 day supply are not eligible for coverage when dispensed by a retail **pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by 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 when dispensed by a **network mail order pharmacy**.

Network Benefits for Specialty Care Drugs *(GR-9N 13-009-01)*

Self-injectable drugs are covered at the network level of benefits only when dispensed through a **network retail pharmacy** or **Aetna's specialty pharmacy network**. Refer to the **preferred drug guide** for a list of **self-injectable drugs**. You may refer to **Aetna's** website, www.aetna.com to review the list anytime. The list may be updated from time to time.

The initial prescription for a **self-injectable drug** must be filled at a **network retail pharmacy** or at **Aetna's specialty pharmacy network**.

Other Covered Expenses *(GR-9N 13-005 01 OH)*

The following **prescription drugs**, medications and supplies are also **covered expenses** under this Coverage.

Off-Label Use *(GR-9N 13-005 01 OH)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia adopted by the United States Department of Health and Human Services, or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **Aetna's** sole discretion, be subject to **precertification**, or other **Aetna** requirements or limitations.

Diabetic Supplies *(GR-9N 13-005 01 OH)*

The following diabetic supplies upon prescription by a **physician**:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Contraceptives *(GR-9N 11-006 04 NG OH)*

Covered expenses include charges made by a **network pharmacy** for the following contraceptive methods when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing:

- Female oral and injectable contraceptives that are **generic prescription drugs**.
- Female contraceptive devices.
- FDA-approved female:
  - Generic, emergency contraceptives; and
  - Generic over-the-counter (OTC) emergency contraceptives obtained without a **prescription**.
- FDA-approved female generic over-the-counter (OTC) contraceptives;

Important Note:
This Plan does not cover all contraceptives. For a current listing, contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Contraceptives can be paid either under your medical plan or **pharmacy** plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive p**rescription drugs** and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit.

Refer to the Copay and Deductible Waiver section of your Schedule of Benefits for cost-sharing information.

Important Notes:

1. The Copay and Deductible Waiver does <u>not</u> apply to contraceptive methods that are:
   - **Brand-name prescription drugs**;
   - FDA-approved female:
     - brand-name emergency contraceptives; and
     - brand-name over-the-counter (OTC) emergency contraceptives; and
   - FDA-approved female brand-name over-the-counter (OTC) contraceptives.

   However, the Copay and Deductible Waiver does apply when:

- such contraceptive methods are not available within the same **therapeutic drug class**; or
- a generic equivalent, biosimilar or generic alternative, within the same **therapeutic drug class** is not available; and
- you are granted a medical exception. Refer to Medical Exceptions described below; above in the Precertification section for information on how you or your **prescriber** can obtain a medical exception.

2. A generic equivalent contains the identical amounts of the same active ingredients as the **brand-name prescription drug** or device. A generic alternative is used for the same purpose, but can have different ingredients or different amounts of ingredients.

Oral and Self-Injectable Infertility Drugs

The following **prescription drugs** used for the purpose of treating infertility including, but not limited to:

- Urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

Preventive Care Drugs and Supplements *(GR-9N 13-022 01 NG OH)*

Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a **network pharmacy**. They are covered when they are:

- prescribed by a **physician**;
- obtained at a **pharmacy;** and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this Plan include, but may not be limited to:

- Aspirin: Benefits are available to adults.
- Folic Acid Supplements: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- Iron Supplements: Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- Oral Fluoride Supplements: Benefits are available to children whose primary water source is deficient in fluoride.
- Vitamin D Supplements: Benefits are available to adults to promote calcium absorption and bone growth in their bodies.
- Risk-Reducing Breast Cancer Prescription Drugs**. Covered medical expenses** include charges incurred for **generic prescription drugs** prescribed by a **physician** for a woman who is at increased risk for breast cancer and is at low risk for adverse medication side effects.

Coverage for preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

The federal website is included here for your reference:

http://www.healthcare.gov/center/regulations/prevention.html

The covered preventive drugs are governed by the USPSTF and HRSA – the link below includes those preventive care drugs and supplements listed above:

http://www.uspreventiveservicestaskforce.org/BrowseRec

Important Note:
For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com and Aetna Navigator, or calling the number on the back of your ID card.

Tobacco cessation prescription and over-the-counter drugs *(GR-9N 13-022 01 NG OH)*

Covered expenses 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.

Refer to the Schedule of Benefits for the cost-sharing and supply limits that apply to these benefits.

Precertification *(GR-9N-S-13-010-01 OH)*

Precertification is required for certain outpatient **prescription drugs**. **Prescribers** must contact **Aetna** to request and obtain coverage for such **prescription drugs**. The list of drugs requiring **precertification** is subject to periodic review and change by **Aetna**. For the most up to date information, call the toll-free number on your member ID card or log on to your Aetna Navigator secure member website at www.aetna.com.

Benefits will be reduced if **Aetna** does not **precertify** your **prescription drug**. So ask your **prescriber** or pharmacist if your **prescription drug** needs to be **precertified.**

How to Obtain Precertification *(GR-9N-S-13-010-01 OH)*

If an outpatient **prescription drug** requires **precertification** and you use a **network pharmacy** the **prescriber** is required to obtain **precertification** for you.

When you use an **out-of-network pharmacy**, you can begin the **precertification** process by having the **prescriber** call **Aetna** at the number on your ID card.

Aetna will let your **prescriber** know if the **prescription drug** is **precertified.**

If the **prescription drug** is denied **precertification**, **Aetna** will notify you how the decision can be appealed.

Medical Exceptions:

Your **prescriber** may seek a medical exception to obtain coverage for drugs listed on the **formulary exclusions list** or for which coverage is denied through **Precertification**. You or your **prescriber** must submit such exception requests to Aetna. Coverage granted as a result of a medical exception shall be based on an individual, case by case **medical necessity** determination and coverage will not apply or extend to other covered persons.

Pharmacy Benefit Limitations *(GR-9N 13-015 08 OH)*

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.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the *Complaint and Appeals* section(s) of this Booklet-Certificate.

Aetna reserves the right to include only one manufacturer's product on the **preferred drug list** when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

Aetna reserves the right to include only one dosage or form of a drug on the **preferred drug list** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug list** will be covered at the applicable **copayment** or **coinsurance**.

The number of **copayments/deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any **prescription drug** dispensed by a **mail order pharmacy** for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

Some **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your **prescription drug** is used correctly and safely. **Aetna** relies on medical guidelines, FDA-approved recommendations from drug makers and other criteria developed by **Aetna** to set these quantity limits. The quantity limit may restrict either the amount dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to a single commercially prepackaged item excluding insulin, diabetic supplies, test strips dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to 100 units excluding insulin dispensed per **prescription** order or refill.

Any **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**.

Specialty care prescription drugs may have limited access or distribution and are subject to supply limits.

Plan approved blood glucose meters, asthma holding chambers and peak flow meters are **eligible health services**, but are limited to one (1) **prescription** order per **calendar year**.

Pharmacy Benefit Exclusions *(GR-9N 28-020 14 OH)*

Not every health care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are ***not*** covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this *Booklet-Certificate*. In addition, some services are specifically limited or excluded. This section describes expenses that are ***not*** covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

Abortion drugs.

Administration or injection of any drug.

Any charges in excess of the benefit, day, or supply limits stated in this *Booklet-Certificate*.

Allergy sera and extracts administered via injection.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this *Booklet-Certificate*. This also includes **prescription drugs** or supplies if:

- Such **prescription drugs** or supplies are unavailable or illegal in the United States, or
- The purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Any drugs or medications, services and supplies that are not **medically necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**. This does not apply to mandated preventive care drugs.

Biological sera, blood, blood plasma, blood derivatives or substitutes or any other blood products.

Contraceptive **prescription drugs**, devices, services and supplies (except as specifically described in the *Preventive Care Benefits* and *Additional Covered Expenses* section) including:

- Services associated with the prescribing, monitoring and/or administration of **prescription drug** contraceptives and devices.
- Female contraceptives that are **brand-name prescription drugs** and biosimilar **prescription drugs**; and
- FDA-approved female brand-name and biosimilar emergency contraceptives.

Contraception – Male condoms.

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 specifically covered in the *What the Plan Covers* section.

Dietary supplements including medical foods.

Drugs administered or entirely consumed at the time and place it is prescribed or dispensed.

Drugs for which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration).

Drugs not approved by the FDA or not proven safe and effective.

Drugs recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Aetna's** Pharmacy and Therapeutic Committee.

Drugs 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 covered in the *What the Pharmacy Plan Covers* section.

Drugs provided under your medical plan while an inpatient of a healthcare facility.

Drugs that include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF).

Drugs used for methadone maintenance medications used for drug detoxification.

Drugs 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; and
- other medications.

Drugs used for the treatment of obesity.

Drugs that are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile dysfunction, enhance sensitivity, or alter the shape or appearance of a sex organ.

All 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.

Drugs or medications that include the same active ingredient or a modified version of an active ingredient as a covered prescription drug (unless a medical exception is approved).

Drug or medication that is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** including biosimilars.

Drug or medication that is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product.

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

Durable medical equipment, monitors and other equipment.

Experimental or investigational drugs or devices, except as described in the *What the Plan Covers* section.

This exclusion will ***not*** apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the **illness**.

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

Genetics: Any treatment, device, drug, 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.

Immunization or immunological agents.

Immunizations related to travel or work.

Implantable drugs and associated devices.

Self-injectables:

- Any charges for the administration or injection of **prescription drugs** or self-injectable insulin and other injectable drugs covered by **Aetna e**xcept as described in the *What the Plan Covers* section;
- Needles and syringes, except those used for self-administration of an self-injectable drug;
- For 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 self-injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

Medications or preparations used for cosmetic purposes.

Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

Prescription drugs, medications, self-injectables or supplies provided through a third party vendor contract with the policyholder.

Prescription drugs listed in the **formulary exclusions** list in the **preferred drug guide** unless a medical exception has been obtained.

Prescription drugs 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.

Prescription drugs that include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is no clinically superior to that drug as determined by the plan.

Prescription drugs that are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition.

Prescription drugs that are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered 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.

Prescription drugs 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.

Prescription orders filled prior to the effective date or after the termination date of coverage under this Booklet-Certificate.

Refills in excess of the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or evidence as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescription**s.

Drugs, services and supplies provided in connection with treatment of an **occupational injury** or **occupational illness**.

Tobacco use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum that is not recommended by the United States Preventive Services Task Force (USPSTF).

Strength and performance: Drugs or preparations, devices or supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

When Coverage Ends *(GR-9N-30-015-04)*

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

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, **Aetna** may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not actively at work due to **illness or injury**, your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

Your Proof of Prior Medical Coverage *(GR-9N-30-010-01 OH)*

Under the Health Insurance Portability and Accountability Act of 1996, you are entitled to receive a certificate of **creditable coverage** when your employment ends. This certificate proves that you had **creditable coverage** when you were employed. Ask your employer about the certificate of **creditable coverage**.

When Coverage Ends for Dependents *(GR-9N-30-015-02)*

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

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

Continuation of Coverage *(GR-9N-31-015-05)*

Continuing Health Care Benefits *(GR-9N-31-015-06)*

Continuing Coverage for Dependent Students on Medical Leave of Absence *(GR-9N 31-015 01 OH)*

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

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

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

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

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

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

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

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

Handicapped Dependent Children *(GR-9N 31-015 01 OH)*

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child.

Your child is fully handicapped if:

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

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 90 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.

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

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

Continuing Coverage for Reservist Called to Active Duty

Any eligible person may continue health care benefits under the group policy for a period of 18 months after the date on which a reservist's coverage under the group policy would otherwise end because he or she was called to active duty.

The term "eligible person" means you, if you are a reservist called to active duty, and your covered spouse and dependent children. The term "reservist" means a member of a reserve component of the armed forces of the United States including the Ohio National Guard.

If you are a reservist and are called to active duty, your employer shall notify each eligible person of this continuation right and explain how to enroll for this continued coverage and the amount of the required contribution. The eligible person must elect continuation and pay the required contribution to the employer by the earlier of:

- 31 days after the date coverage would otherwise terminate;
- 31 days after the date your employer notifies the eligible person of the right to continuation.

Coverage may be extended up to a 36 month period if any one of the following occurs during the 18 month continuation:

- The death of the reservist;
- The divorce or separation of a reservist from the reservist's spouse;
- The child no longer qualifies as a dependent child under the terms of the group policy.

The 36 month period is deemed to begin on the date of any occurrence above.

Coverage under this continuation as to an eligible person will end on the earlier to occur of the following:

- The 18 month, or if applicable, the extended 36 month period, expires.
- Required contributions are not made when due.
- The eligible person enrolls in another group health policy that does not contain a preexisting conditions limitation or exclusion.
- The group policy is terminated, unless replaced by similar coverage.

Extension of Benefits *(GR-9N 31-020 01)*

Coverage for Health Benefits

If your health benefits end while you are totally disabled, your health expenses will be extended as described below, but, with respect to medical benefits, only as to expenses incurred in connection with the **injury** or **illness** that caused the total disability. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

"Totally disabled" means that because of an **injury** or **illness**:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage *(GR-9N 31-020 01)*

(GR-9N 31-020 01)
Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

Prescription Drug Benefits: Coverage will be available while you are totally disabled for up to 12 months.

When Extended Health Coverage Ends
Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

Important Note
If the Extension of Benefits provision outlined in this section applies to you or your covered dependents, see the *Converting to an Individual Health Insurance Policy* section for important information.

COBRA Continuation of Coverage *(GR-9N 31-025-06 OH)*

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a "qualifying event" that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA
When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer's notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

Who Qualifies for COBRA
You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
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 dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events.

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Premium Payments for Continuation Coverage

Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 % of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 % of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

Important Note

For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

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

(GR-9N 33-005-01-OH)

When Coordination of Benefits Applies

General

A. This coordination of benefits ("COB") provision applies to **This Plan** when an employee or the employee's covered dependent has health care coverage under more than one plan. "**Plan**" and "**This Plan**" are defined below.
B. If this COB provision applies, you should look first at the order of benefit determination rules. Those rules determine whether the benefits of **This Plan** are determined before or after those of another plan. The benefits of **This Plan**:
   - Shall not be reduced when, under the order of benefit determination rules, **This Plan** determines its benefits before another plan; but
   - May be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

Getting Started - Important Terms

A. "**Plan**" means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
   - Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other then school accident-type coverage.
   - Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
   - "**Plan**" does not include school accident-type coverage, individual contracts of coverage, or some supplemental sickness and accident policies.
   - Each contract or other arrangement for coverage under (1) or (2) is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate plan.
B. "**This Plan**" is the part of this group contract that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" the order of benefit determination rules state whether **This Plan** is a Primary Plan or Secondary Plan as to another plan covering the person. When **This Plan** is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When **This Plan** is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, **This Plan** may be a Primary Plan as to one or more other plans and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered by this plan. However, **This Plan** is not required to pay for an item, service, or benefit which is not a part of this **Plan's** contract. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

Which Plan Pays First *(GR-9N 33-010-01-OH)*

A. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan whose benefits are determined after those of the other plan, unless:
   1) The other plan has rules coordinating its benefits with those of This Plan; and
   2) Both those rules and this plan's rules, in subsection below, require that this plan's benefits be determined before those of the other plan.

B. This Plan determines its order of benefits using the first of the following rules which applies:
   1) The benefits of the plan which covers the person as an employee, member, insured, or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is;
      - Secondary to the plan covering the person as a dependent and
      - Primary to the plan covering the person as other than a dependent (e.g. a retired employee).
   2) Benefits for a dependent child whose parents are not separated or divorced shall be determined as follows:
      - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
      - If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which has covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (A) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

   3) Benefits for a dependent child whose parents are divorced or separated shall be determined as follows. To the extent the plan has been notified by receiving a copy of the court decree:
      - If the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, the benefits of the plan of that parent are determined first. The plan of the other parent shall be the Secondary Plan.
      - If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall be subject to the order of benefit determination contained in subdivision (B)(2) of this section.

If neither subdivision (A) nor (B) applies, the order of benefits shall be determined in the following order:

1) The plan of the parent with custody of the child;
2) The plan of the spouse of the parent with the custody of the child;
3) The plan of the parent not having custody of the child; and
4) The plan of the spouse of the parent not having custody of the child.
5) The benefits of a plan which covers a person as an employee who is neither laid off not retired (or as that employee's dependent) are determined before the benefits of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph shall be ignored.

6) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (i.e., COBRA) or state law also is covered under another plan, the benefits of the plan covering the person as employee, member or subscriber (or that person's dependent) shall be determined before the benefits under the continuation coverage. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph shall be ignored.
7) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

How Coordination of Benefits Works

A. This section applies when, in accordance with the "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in (B) below.
B. Reduction in This Plan's benefits. The benefits of This Plan will be reduced to the extent that the sum of:
   - The benefits that would be payable for the allowable expense under This 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 claim is made, exceeds those allowable expenses.

If the allowable expense under This Plan is lower than the primary plan's, Aetna will use the primary plan's allowable expense. That may be lower than the actual bill.

Right To Receive And Release Needed Information *(GR-9N 33-015-01-OH)*

Certain facts are needed to apply these COB rules. **Aetna** has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. **Aetna** need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give **Aetna** any facts it needs to pay the claim.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Another plan; or
- The provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686- 1526.

When You Have Medicare Coverage

(GR-9N-33-020-01)

This section explains how the benefits under **This Plan** interact with benefits available under **Medicare**.

Medicare, when used in this Booklet-Certificate, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It 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** if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under it because you:
  1. Refused it;
  2. Dropped it; or
  3. Failed to make a proper request for it.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the primary payor, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the secondary payor, and pays benefits after **Medicare**.

Which Plan Pays First

The plan is the primary payor when your coverage for the **plan**'s benefits is based on current employment with your employer. The **plan** will act as the primary payor for the **Medicare** beneficiary who is eligible for **Medicare**:

- Solely due to age if the **plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for **Medicare** benefits. This provision does not apply if, at the start of eligibility, you were already eligible for **Medicare** benefits, and the **plan**'s benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the **plan** meets the definition of a large group health plan as outlined in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

The **plan** pays benefits first when it is the primary payor. You may then submit your claim to **Medicare** for consideration.

When Medicare is Primary

Your health care expense must be considered for payment by **Medicare** first. You may then submit the expense to **Aetna** for consideration.

Aetna will calculate the benefits the **plan** would pay in the absence of **Medicare**:

The amount will be reduced so that when combined with the amount paid by **Medicare**, the total benefits paid or provided by all plans for the claim do not exceed 100 % of the total **allowable expense**.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **plan** in the order received by **Aetna**. **Aetna** will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information *(GR-9N-33-025-01)*

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **This Plan** and other **plans**. **Aetna** has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

General Provisions *(GR-9N-32-005-02)*

Type of Coverage

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

Physical Examinations

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

Legal Action

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

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of the plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna**'s Notice of Information Practices by calling **Aetna**'s toll-free Member Service telephone.

Additional Provisions

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *group policy*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

Assignments *(GR-9N-32-005-02-OH)*

Coverage may be assigned only with the written consent of **Aetna**. To the extent allowed by law, **Aetna** will not accept an assignment to an **out-of-network provider**, including but not limited to, an assignment of:

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

Misstatements *(GR-9N-32-005-03)*

If any fact as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by you, an eligible employee or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Rescission of Coverage *(GR-9N-32-005-03)*

Aetna may rescind your coverage if you, or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage.

As to medical and prescription drug coverage only, you have the right to an internal **Appeal** with **Aetna** and/or the right to a third party review conducted by an independent **External Review** Organization if your coverage under this Booklet-Certificate is rescinded retroactive to its Effective Date.

Subrogation and Right of Reimbursement *(GR-9N-32-010-01-OH)*

As used herein, the term "**Third Party**", means any party that is, or may be, or is claimed to be responsible for **illness** or **injuries** to you. Such **illness** or **injuries** are referred to as "**Third Party Injuries**." "**Third Party**" includes any party responsible for payment of expenses associated with the care of treatment of **Third Party Injuries**.

If this plan pays benefits under this Booklet-Certificate to you for expenses incurred due to **Third Party Injuries**, then **Aetna** retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the **Third Party Injuries**. **Aetna**'s rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a **Third Party** or any insurance company on behalf of the **Third Party**;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for **injuries** resulting from an accident or alleged negligence with the exception of claims by you pursuant to the property damage provisions of any insurance policy.

By accepting benefits under this plan, you specifically acknowledge **Aetna**'s right of subrogation. When this plan pays health care benefits for expenses incurred due to **Third Party Injuries**, **Aetna** shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this plan. **Aetna** may proceed against any party with or without your consent.

By accepting benefits under this plan, you also specifically acknowledge **Aetna**'s right of reimbursement. This right of reimbursement attaches when this plan has paid benefits due to **Third Party Injuries** and you or your representative has recovered any amounts from a **Third Party**. By providing any benefit under this Booklet-Certificate, **Aetna** is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. **Aetna**'s right of reimbursement is cumulative with and not exclusive of **Aetna**'s subrogation right and **Aetna** may choose to exercise either or both rights of recovery.

By accepting benefits under this plan, you or your representatives further agree to:

- Notify **Aetna** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to **Third Party Injuries** sustained by you;
- Cooperate with **Aetna** and do whatever is necessary to secure **Aetna**'s rights of subrogation and reimbursement under this Booklet-Certificate;
- Give **Aetna** a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with **Third Party Injuries** provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due **Aetna** as reimbursement for the full cost of all benefits associated with **Third Party Injuries** paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **Aetna** in writing; and
- Do nothing to prejudice **Aetna**'s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of **Third Party Injuries**.

Aetna may recover full cost of all benefits paid by this plan under this Booklet-Certificate without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **Aetna**'s recovery, and **Aetna** is not required to pay or contribute to paying court costs or attorney's

fees for the attorney hired by you to pursue your claim or lawsuit against any **Third Party** without the prior express written consent of **Aetna**. In the event you or you representative fail to cooperate with **Aetna**, you shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by **Aetna** in obtaining repayment.

Workers' Compensation

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

The Recovery Rights will be applied even though:

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

You hereby agree that, in consideration for the coverage provided by this policy, you will notify **Aetna** of any Workers' Compensation claim you make, and that you agree to reimburse **Aetna** as described above.

If benefits are paid under this policy and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna** has a right to recover from you or your covered dependent an amount equal to the amount **Aetna** paid.

Recovery of Overpayments *(GR-9N-32-015-01-OH)*

Health Coverage

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

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

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

Reporting of Claims

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

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

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

Payment of Benefits *(GR-9N-32-025-02)*

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

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

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

Any unpaid balance will be paid within 30 days of receipt by **Aetna** of the due written proof.

Aetna may pay up to $1,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

When a **PCP** provides care for you or a covered dependent, or care is provided by **a network provider** (**network services or supplies**), the **network provider** will take care of filing claims. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

Records of Expenses *(GR-9N-32-030-02)*

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

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

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Effect of Benefits Under Other Plans *(GR-9N 32-035-01)*

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

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care), if any, on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

Any extensions of benefits under this plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan providing medical coverage. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- The end of a 90 day period; and
- The date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Prior Coverage - Transferred Business *(GR-9N-32-040-02)*

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

coverage under any Major or Comprehensive Medical Expense Coverage section of this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided under the section, *Continuing Coverage for Dependent Students on Medical Leave of Absence*.

Discount Programs *(GR-9N-32-045-01-OH)*

Discount Arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third party service **providers**". These third party service

providers may pay us so that they can offer you their services.

The third party service **providers** are independent contractors. The third party service provider is responsible for the goods or services they deliver.

We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service **providers** for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and Other Incentives *(GR-9N-32-045-01-OH)*

Aetna may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and continue participation as an **Aetna** member through incentives. You and your **physician** can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, **Aetna** may provide incentives based on your participation and your results. Incentives may include but are not limited to:

- Modifications to **copayment**, **deductible**, or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards, or
- Any combination of the above.

Appeals Procedure *(GR-9N 32-050 02 OH)*

Definitions

Adverse Benefit Determination (Decision) means:

A decision by **Aetna**:

- To deny, reduce, terminate or fail to provide or make payment in whole or in part, for a service, supply or benefit. Such **adverse benefit determination** may be include all of the following:
  - Your eligibility for coverage.
  - A determination that the health care services does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments.
  - A determination of your eligibility for individual health insurance coverage, including coverage offered through a non-employer group, to participate in a plan or health insurance coverage.
  - The results of any Utilization Review activities.
  - A determination that a health care service is not a covered benefit.
  - The imposition of an exclusion, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to you, including coverage offered through a non-employer group.
- As to medical and prescription drug claims only, an **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

Appeal: An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

Authorized Representative: An individual who represents you in an internal appeal or external review process of an **adverse benefit determination** who is any of the following:

- A person to whom you have given express, written consent to represent you in an internal appeals process or external review process of an **adverse benefit determination**;
- A person authorized by law to provide substituted consent for you;
- A family member or a treating health care professional, but only when you are unable to provide consent.

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

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

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

Covered Benefits or **Benefits:** Those health care services to which a covered person is entitled under the terms of a health benefit plan.

Covered Person: Policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's **authorized representative** with regard to an internal appeal or external review.

Emergency Services:

- A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;
- Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the **appeals** process.

Health Benefit Plan: A policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Health Care Services: Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Plan Issuer: An entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the **superintendent** of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health Plan Issuer" includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the **superintendent**.

Independent Review Organization: An entity that is accredited to conduct independent external reviews of **adverse benefit determinations**.

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

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

Rescission or **to rescind:** A cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Stabilize: The provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
    - Serious impairment to bodily functions;
    - Serious dysfunction of any bodily organ or part.
- In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Superintendent: The Superintendent of Insurance.

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

- Seriously jeopardize your life or health;
- Affect you or others safety due to the patient's psychological state;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and appeals only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and **prescription drug** claims only, if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a **concurrent care claim**, to your **provider**.

Urgent Care Claims

Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than 48 hours after the claim is made.

If more information is needed to make an urgent claim decision, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the **physician** to provide **Aetna** with the information.

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

The **precertification** request may be submitted through a secure electronic transmission. **Aetna** will respond in the same manner as indicated above. A facsimile is not considered a secure electronic transmission. **Aetna** will provide an electronic receipt acknowledging the request and receipt of any additional information.

Pre-Service Claims

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

If the **precertification** request is submitted through a secure electronic transmission, **Aetna** will respond to the request within 10 calendar days with an approval or denial. **Aetna** will provide an electronic receipt acknowledging the request and receipt of any additional information.

- If the **precertification** is denied, **Aetna** will let your **provider** know the specific reason for the denial.
- If the request is incomplete **Aetna** will let your **provider** know what specific information is required to process the request.

A facsimile is not considered a secure electronic transmission.

Post-Service Claims

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

Concurrent Care Claim Extension

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

Concurrent Care Claim Reduction or Termination

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

If you file an **appeal**, coverage under the plan will continue for the previously approved ongoing course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints

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

Notice of an Adverse Determination

When **Aetna** notifies you of an **adverse benefit determination** in writing, you will also be notified of your right to an **external review**. As part of the written notice, the Plan will include the following:

- Sufficient information to identify the claim or health care service involved, including the health care provider, and the date of service and claim amount, if applicable;
- A description of the reason or reasons for the **adverse benefit determination**, including the denial code, such as the claim adjustment reason code and the remittance advice remark code, and each code's corresponding meaning;
- A description of the available internal **appeals** and **external review** processes, including information regarding how to initiate an **appeal** and an **external review**; and
- Disclosure of the availability of assistance from the **superintendent** with the internal appeals and external review processes, including the web site, telephone number, and mailing address of the **superintendent's** Office of Consumer Services.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level of **appeal**. A **final adverse benefit determination** notice will also provide an option to request an **External Review** if the services are eligible for external review.

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an **adverse benefit determination** to request your **appeal**. Your **appeal** may be submitted orally or be submitted in writing and must include:

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

Send your written **appeal** to Member Services at the address shown on your ID Card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna.**

Appeal

A review of an **appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 48 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

If the appeal request is submitted through a secure electronic transmission, **Aetna** will respond to the request within 10 calendar days with an approval or denial. A facsimile is not considered a secure electronic transmission.

If the appeal does not resolve the matter, you or your authorized representative may request an external review.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**. If the appeal does not resolve the matter, you or your authorized representative may request a second level of **appeal** before proceeding to appeal through an external review. Both first and second level **appeals** must be completed within 10 days.

Exhaustion of Process

In some situations you must exhaust the applicable level one and level two processes of the Appeal Procedure before you:

- Contact the Ohio Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Ohio Department of Insurance; or
- Establish any:
  Litigation;
  Arbitration; or
  Administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

Exceptions to the exhaustion of the level one and level two processes of the **Appeals** procedure may occur in the following instances:

a) **Aetna** agrees to waive the Exhaustion requirement;
b) You did not receive a written decision of **Aetna's** internal **appeal** within the required timeframe;
c) **Aetna** fails to meet all requirements of the internal appeals process unless the failure:
    - was *de minimis*;
    - does not cause or is not likely to cause prejudice or harm to you;
    - was for good cause and beyond the control of the Plan; or
    - is not reflective of a pattern or practice of non-compliance.
d) an expedited **external review** is sought simultaneously with an expedited internal review.

An internal **appeal** process shall be considered exhausted if you have requested an internal **appeal** and have not received a written decision from **Aetna** at each level of **appeal** within the timeframes listed above and **Aetna** fails to adhere to all requirements of the internal **appeals** process.

You may not request an **external review** of an **adverse benefit determination** involving a retrospective utilization review decision until **Aetna's** internal **appeal** process has been exhausted unless the **Aetna** agrees to waive the exhaustion requirement

Under certain circumstances, you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

If **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or **appeal** straight to an **External Review**. Your claim or internal **appeal** will not go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.

Glossary

(GR-9N 34-005 01)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

A *(GR-9N-34-005-05)*

Aetna

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

Ambulance

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

Average Wholesale Price (AWP)

The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

B *(GR-9N-34-010-02-OH)*

Behavioral Health Provider/Practitioner

A licensed facility, organization or **other health care** provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, **mental disorder**s or **biologically-based mental illnesses** acting within the scope of the applicable license. This includes:

- **Hospitals**;
- Psychiatric **hospitals**;
- **Physicians**, including those licensed to practice osteopathic medicine and surgery;
- **Residential treatment facilities**;
- **Psychiatric physicians**;
- Psychologists;
- Social workers;
- Psychiatric nurses;
- Clinical nurse specialists whose nursing specialty is mental health;
- Addictionologists;
- Professional counselors;
- Professional clinical counselors;
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

Birthing Center

A freestanding facility that meets ***all*** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.

- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index
This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand-Name Prescription Drug
A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

C *(GR-9N 34-015 02)*

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

Coinsurance Limit
Coinsurance limit is the maximum out-of-pocket amount you are responsible to pay for **coinsurance** for **covered expenses** during your calendar year. Once you satisfy the **coinsurance limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the calendar year. You have a separate **coinsurance limit** for out-of-network expenses and a separate maximum out-of-pocket limit for in-network expenses.

Copay or Copayment
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

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

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this Booklet-Certificate.

Creditable Coverage
A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

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

D *(GR-9N 34-020 06)*

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

Dentist
A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Detoxification *(GR-9N 34-020 06)*

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

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

as determined by a **physician** 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 take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

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

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory

A listing of all **network providers** serving the class of employees to which you belong. The policyholder will give you a copy of this **directory**. **Network provider** information is available through **Aetna's** online provider **directory**, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this **directory**.

Durable Medical and Surgical Equipment (DME)

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

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

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

E *(GR-9N 34-25 09)*

Emergency Admission

An admission to a **hospital** or treatment facility by a **physician** who admits you right after the sudden and, at that time, unexpected onset of an **emergency medical condition** which requires confinement right away as a full-time stay.

Emergency Care

This means the treatment given in a hospital's emergency room to evaluate and treat an **emergency medical condition**, including the following:

- A medical screening examination, as required by federal law, that is within the capability of the hospital's emergency room, including ancillary services routinely available to the emergency room, to evaluate an **emergency medical condition**; and
- Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the **hospital**, including any trauma and burn center of the **hospital**.

As used in the preceding paragraph, the term "stabilize" means, to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Emergency Medical Condition

A medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

Experimental or Investigational

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

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

G *(GR-9N 34-035 01)*

Generic Prescription Drug
A **prescription drug**, that is identified by its:
- chemical;
- proprietary; or
- non-proprietary name; and
- is accepted by the U.S. Food and Drug Administration as therapeutically the same; and
- can be replaced with drugs with the same amount of active ingredient; and
- so stated by Medispan or any other publication named by **Aetna** or consort.

H *(GR-9N 34-040 02)*

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

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

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

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency
An agency that meets all of the following requirements.

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

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

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

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

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

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.

- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

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

Hospice Facility

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

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

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;

- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

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

I *(GR-9N 34-045 02)*

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

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

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

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

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

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

J *(GR-9N 34-050 01)*

Jaw Joint Disorder *(GR-9N 34-050 01)*
This is:

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

L *(GR-9N 34-055 01)*

Late Enrollee
This is an employee in an Eligible Class who asked for enrollment under this Plan after the Initial Enrollment Period. Also, this is an eligible dependent for whom the employee did not choose coverage for the Initial Enrollment Period, but for whom coverage is asked for at a later time.

An eligible employee or dependent may not be considered a **Late Enrollee** at certain times. See the Special Enrollment Periods section of the (Booklet-Certificate).

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

M *(GR-9N-34-065-03 OH)*

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

Maintenance Care
Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Out-of-Pocket Limit
Your plan has a **maximum out-of-pocket limit**. Your **deductibles**, **coinsurance**, **copayments** and other eligible out-of-pocket expense apply to the **maximum out-of-pocket limit**. Once you meet the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the **Calendar Year**. You have a separate **maximum out-of-pocket limit** for network and out-of-network out-of-pocket expenses.

Non-covered expenses and certain **covered expenses** do not apply toward your **maximum out-of-pocket limit**. Please refer to your *Summary of Benefits* for details regarding the type of expenses and specific expenses that are not counted toward your **maximum out-of-pocket limit**.

Medically Necessary or Medical Necessity
These are health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must be:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and

c) Not mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

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

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

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

N *(GR-9N 34-070 02)*

Negotiated Charge *(GR-9N-34-070-11 OH)*

As to health expense coverage, other than Prescription Drug Expense Coverage, this is either:

- The amount a **network provider** has agreed to accept
- The amount **Aetna** agrees 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.**

As to Prescription Drug Expense Coverage:
The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Advanced Reproductive Technology (ART) Specialist

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

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

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

Network Service(s) or Supply(ies)
Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **PCP**.

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

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

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

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

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

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

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

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

Non-Preferred Drug (Non-Formulary)
A **prescription drug** that is not listed in the **preferred drug guide**. This includes **prescription drugs** on the **preferred drug guide exclusions list** that are approved by medical exception.

Non-Specialist
A **physician** who is not a **specialist**.

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

O *(GR-9N-34-075-01 OH)*

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

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

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

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

Orthodontic Treatment *(GR-9N-34-075-01 OH)*
This is any:

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

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

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

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

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

Out-of-Network Service(s) and Supply(ies) *(GR-9N-34-075-01 OH)*
Health care service or supply that is:

- Furnished by an **out-of network provider**; or
- Not furnished or arranged by your **PCP**.

Out-of-Network Provider
A health care provider or **pharmacy** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

P *(GR-9N-34-80-09)*

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

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

Partial Hospitalization Treatment *(GR-9N-34-080-10 OH)*
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. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician
A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

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

Preferred Drug Guide
A listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Preferred Drug Guide Exclusions List
A list of **prescription drugs** in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna**.

Preferred Network Pharmacy
A **network retail pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** that we have identified as a **preferred network pharmacy**.

Prescriber
Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug
A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Physician (PCP)
This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on **Aetna**'s records as the person's **PCP**.

Psychiatric Hospital *(GR-9N-34-080-10 OH)*
This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or **mental disorders (including substance-related disorders)**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**

- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a **physician** who:

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

R *(GR-9N-34-090-01 OH)*

Recognized Charge *(GR-9N-34-090-17)*

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.

In all cases, the **recognized charge** is determined based on the Geographic Area where you receive the service or supply.

Recognized charge does not apply to involuntary services.
Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider** bills and:

- For professional services and for other services or supplies not mentioned below:
  - 300% of the Medicare allowable rate

- For services of **hospitals** and other facilities:
  - 300% of the Medicare allowable rate

- For **prescription drugs**:
  - 110% of the Average wholesale price (AWP)

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.** Except for involuntary services, when you get care from a NAP **provider** your **out-of-network** cost sharing applies.

We have the right to apply **Aetna** reimbursement policies. Those policies may further reduce the **recognized charge.** These policies take into account factors such as:

- 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 incidental to the primary service provided and
- The educational level, licensure or length of training of the **provider**

Aetna 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 and
- The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used
Average wholesale price (AWP), Geographic area, Involuntary services, and Medicare allowable rates are defined as follows:

Average wholesale price (AWP)
Is the current average wholesale price of a **prescription drug** listed in the Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).

Geographic area
The Geographic area made up of 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
Involuntary services are services or supplies that are:

- Performed at a **network** facility by an **out-of-network provider,** unless that **out-of-network provider** is an assistant surgeon for your surgery, or
- Not available from a **network provider**, or
- **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 allowable rates
Except as specified below, these 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 will determine the rate as follows:

- Use the same method CMS uses to set Medicare rates.
- Look at what other providers charge.
- Look at how much work it takes to perform a service.
- Look at other things as needed to decide what rate is reasonable for a particular service or supply.

Additional information:
Get the most value out of your benefits. Use the "Estimate the Cost of Care" tool on Aetna Navigator® to help decide whether to get care in network or out-of-network. **Aetna's** secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

Rehabilitation Facility
A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

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

Residential Treatment Facility (Mental Disorders) *(GR-9N-34-090-17)*

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

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Residential Treatment Facility (Substance Abuse)

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

- Has, on site, licensed **behavioral health provider**, medical or alcoholism or drug abuse health care providers 24 hours per day;
- Provides a comprehensive patient assessment;
- Has the ability to assess and recognize withdrawal complications that threaten life or bodily functions, and to obtain needed services either on-site or externally;
- Has 24 hour supervision with evidence of close and frequent observation;
- Has medical treatment available, actively supervised by an attending **physician** or **psychiatric physician**;
- Provides living arrangements that foster community living and peer interaction and are consistent with developmental needs;
- Offers group therapy sessions;
- Has the ability to involve family and other support systems in therapy;
- Has individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Provides a level of skilled intervention consistent with patient risk;
- Provides active discharge planning initiated upon admission to the program;
- Can make referrals to, or has a connection with appropriate alcoholism and drug abuse programs during residential treatment, and following discharge;
- Meets any applicable licensing standards established by the jurisdiction in which it is located;
- Charges patients for its services.

R.N.

A registered nurse.

Room and Board

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

S *(GR-9N 34-95-10)*

Self-injectable Drug(s)
Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

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

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

Skilled Nursing Facility
An institution that meets all of the following requirements:

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

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

Skilled nursing facility does not include:

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

Skilled Nursing Services
Services that meet all of the following requirements:

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

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

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

Specialty Care Drugs
Injectable, infusion and oral **prescription drugs** that are prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis.
You can access the list of these **specialty care prescription drugs** by calling the toll-free number on your Member ID card or by logging on to your Aetna Navigator® secure member website at www.aetna.com

Specialty Pharmacy Network
A network of pharmacies designated to fill **specialty care drugs**.

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

Step Therapy
A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

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

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

Must have all of the following:

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

Substance Abuse *(GR-9N 34-095-11 OH)*

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

T *(GR-9N 34-100-06)*

Telemedicine *(GR-9N 34-100 09)*

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service.

Services can be provided by:

- Two-way audiovisual teleconferencing
- Telephone calls, except for behavioral health services
- Any other method required by state law

Terminally Ill (Hospice Care)

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

Therapeutic Drug Class

A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

U *(GR-9N 34-105 02 OH)*

Urgent Admission

A **hospital** admission by a **physician** due to:

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

Urgent Care Facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Charges for its services and supplies.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician**'s office, but only one that:
  - Has contracted with **Aetna** to provide urgent care; and
  - Is, with **Aetna**'s consent, included in the **directory** as a network **urgent care provider**.

It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

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

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

W *(GR-9N 34-110 01)*

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. They are an alternative to a **physician's** office visit for:

- treatment of unscheduled;
- non-emergency **illnesses;** and
- **Injuries;** and
- the administration of certain immunizations.

It is not an alternative for emergency room services or the ongoing care provided by a **physician**. Neither an emergency room, nor the outpatient department of a **hospital**, shall be considered a **Walk-in Clinic**.

AETNA LIFE INSURANCE COMPANY

Patient Protection and Affordable Care Act *of 2010*

AMENDMENT
(GR-9N-PPACA-NG/PPO 01 OH)

This Amendment amends your health benefit plan (Plan), and becomes a part of your Plan as of January 1, 2018, the Effective Date. Please place this Amendment with your Certificate of Coverage for future reference.

On the Effective Date of this **Amendment,** certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010.

Regardless of the terms and conditions of any other provisions of your Plan, this **Amendment** will control.

The following Definition is added to your Plan:
"Essential Health Benefits" is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Your plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this **Amendment.**

Emergency Services
"Stabilize" means, to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department. Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from an out of network provider. However, an out of network provider of Emergency Services may send you a bill for any charges remaining after your Plan has paid (this is called "balance billing").

Except where your Plan provides a better benefit, your Plan will apply the same copayments and coinsurance for out of network Emergency Services as it generally requires for in network Emergency Services. A deductible may be imposed for out of network Emergency Services, only as part of the deductible that generally applies to out of network benefits. Similarly, any out-of-pocket maximum that generally applies to out of network benefits will apply to out of network Emergency Services.

Your Plan will calculate the amount to be paid for out of network Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount your Plan pays to in network providers for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with in-network providers for the services furnished); 2) the amount that would be paid using the same method your Plan generally uses to determine payment for out of network services (such as the usual, customary and reasonable charges), but substituting in network copayments and coinsurance amounts; and (3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any in network copayments or coinsurance.

Lifetime Dollar Limits
The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan's terms, and that Plan is still in effect, you will receive a notice that the lifetime dollar limit no longer applies and that you will have an opportunity to enroll or be reinstated under your Plan. If you are eligible for this enrollment opportunity, you will be treated as a special enrollee.

Annual Dollar Limits
Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. Your Plan may include other benefits not defined as Essential Health Benefits, and those other benefits may have annual dollar limits. If your Plan has annual dollar limits on Essential Health Benefits they are subject to the following:

For a plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit can be no less than $750,000.

For a plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit can be no less than $1.25 million.

For a plan year beginning on or after September 23, 2012, but before December 31, 2013, the limit can be no less than $2 million.

For a plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan.

Rescission of Coverage
A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

Preventive Health Benefits
Under Ohio law, the following preventive health benefits are required to be provided in your Plan:

- Initial Mammography starting at age 35
- Annual screening for cervical cancer
- Child Health Supervision

Your Plan provides additional coverage for selected preventive services without a copayment, coinsurance or deductible when these services are delivered by a network provider.

Depending upon your age, services may include:

- Screenings and tests for diseases
- Mental Health screenings, including substance abuse
- Healthy lifestyle counseling
- Vaccines and immunizations
- Pregnancy counseling and screenings
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Please contact us at www.aetna.com or the telephone number shown on your Member ID card, if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/center/regulations/prevention.html.

Dependent Coverage (for plans that make dependent coverage available)
This Plan will cover your married or unmarried child as defined in Eligibility and Enrollment section of this Plan until your child reaches age 26.

Your Plan will provide coverage, or offer you the opportunity to purchase coverage, for your unmarried natural child, stepchild, or adopted child until your child reaches age 28 if your child is (1) a resident of Ohio or a full-time student at an accredited public or private institution of higher education; and (2) not employed by an employer who offers any health benefit plan under which your child is eligible for coverage; and (3) not eligible for Medicaid or Medicare.

Internal Claims and Appeals and External Review Process

Definitions

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

Such **adverse benefit determination** may be based on:

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

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

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

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

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

External Review: A review of an adverse benefit determination or a final adverse benefit determination by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner made up of physicians or other appropriate health care providers. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An adverse benefit determination that has been upheld by the Plan at the exhaustion of the appeals process.

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

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

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

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

Full and Fair Review of Claim Determinations and Appeals

The Plan will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the final adverse benefit determination is required to be provided so that you may respond prior to that date.

Prior to issuing a final adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of final adverse determination is required.

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. If the Plan makes an adverse benefit determination, written notice will be provided to you, or in the case of a concurrent care claim, to your provider.

Urgent Care Claims

The Plan will make notification of an urgent care claim determination as soon as possible but not more than 24 hours after the claim is made.

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

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

Pre-Service Claims

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

Post-service Claims

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

Concurrent Care Claim Extension

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

Concurrent Care Claim Reduction or Termination

The Plan will notify you of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

If you file an appeal, coverage under the plan will continue for the previously approved or ongoing course of treatment until a final appeal decision is rendered. During this continuation period, you are responsible for any copayments; coinsurance; and deductibles; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under appeal. If the Plan's initial claim decision is upheld in the final appeal decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints

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

Appeals of Adverse Benefit Determinations

You may submit an appeal if the Plan gives notice of an adverse benefit determination. This Plan provides for one level or two levels of appeal. A final adverse benefit determination notice will also provide an option to request an External Review.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your Level One Appeal. Your appeal must be submitted in writing and must include:

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

Send your written appeal to Member Services at the address shown on your ID Card.

You may also choose to have another person (an authorized representative) make the appeal on your behalf. You must provide written consent to the Plan.

You may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Level One Appeal

A review of a Level One Appeal of an adverse benefit determination shall be provided by Plan personnel. They shall not have been involved in making the adverse benefit determination..

Urgent care claims (May Include concurrent care claim reduction or termination.)
The Plan shall issue a decision within 36 hours of receipt of the request for an appeal.

Pre-service claims (May Include concurrent care claim reduction or termination.)
The Plan shall issue a decision within 15 calendar days of receipt of the request for an appeal.

Post-Service Claims
The Plan shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Level Two Appeal

If the Plan upholds an adverse benefit determination at the first level of appeal, and the reason for the decision was based on medical necessity or experimental or investigational reasons, you or your authorized representative have the right to file a Level Two Appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a Level One Appeal.

Review of a Level Two Appeal of an adverse benefit determination of an urgent care claim, a Pre-Service Claim, or a Post-Service Claim shall be provided by Plan personnel. They shall not have been involved in making the adverse benefit determination.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination.)

The Plan shall issue a decision within 24 hours of receipt of the request for a Level Two Appeal.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination.)

The Plan shall issue a decision within 15 calendar days of receipt of the request for Level Two Appeal.

Post-Service Claims

The Plan shall issue a decision within 30 calendar days of receipt of the request for a Level Two Appeal.

Exhaustion of Process

You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- contact the Ohio Department of Insurance to request an investigation of a complaint or appeal; or
- file a complaint or appeal with the Ohio Department of Insurance; or
- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna; or any matter within the scope of the Appeals Procedure.

Under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and External Review processes—these include Urgent Care Claims and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:
If the Plan does not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the appeal requirements and may proceed with External Review or any of the actions mentioned above.

You or an authorized person may contact the Ohio Department of Insurance in writing to request a review if you have been denied coverage of a health care service on the grounds that the service is not a Covered Medical Expense under the Plan. The Ohio Department of Insurance shall determine whether the health care service is a Covered Medical Expense under the Plan. The Ohio Department of Insurance will notify you and the Plan of its determination or that it is not able to make a determination because the determination involves whether or not the health care service is necessary.

If the determination is based on whether the health care service is necessary you have a right to an External Review.

You can contact the Department of Insurance by writing to 50 W. Town Street, Third Floor Suite 300, Columbus, Ohio 43215 or by calling the Department at 800-686-1526.

External Review

The Plan shall afford you an opportunity for an External Review for a coverage denial when requested by you or an authorized person if:

- The Plan has determined that the health care service is not necessary.
- The service, plus any ancillary services and follow-up care, will cost you more than $500.00.

The Plan does not need to afford External Review if:

- The Department of Insurance has determined that the health care service is not a Covered Medical Expense under the Plan.
- You fail to exhaust Aetna's Appeals Procedure.
- No new clinical information has been submitted to the Plan for a previous External Review for the same denial of coverage.

Your request for External Review must be made within 60 days after receipt of notice from the Department of Insurance of the Plan upholding a denial of coverage. External Review may be requested by you, your authorized person, your provider, or a health care facility rendering health care service to you.

External Review must be requested in writing. Expedited review may be requested orally or by electronic means. Written confirmation must be submitted to the Plan within 5 days after the request is made.

For an expedited review, your provider must certify that your condition could, in the absence of immediate medical attention, result in any of the following:

- Placing your health, or with respect to a pregnant woman, the health of your or the unborn child, in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

External Review Procedure for Terminal Illness

The Plan has an External Review process for coverage decisions for you if all of the following apply:

- You have a terminal condition that has a high probability of causing death with 2 years.
- You request a review within 60 days of receipt of notice from the Department of Insurance that determination requires resolution of medical necessity.
- Your physician certifies the terminal condition.
- Standard therapies have not been effective, are not necessary, or no standard therapies covered under the Plan is more beneficial for your condition.
- Your physician recommends a drug, device, procedure, or other therapy that is likely to be more beneficial than standard therapy; or you request a therapy found in peer-reviewed published studies to have effective clinical outcomes for the same condition.
- You have exhausted the Plan's Appeals Procedure.
- The drug, device, procedure, or other therapy, for which coverage has been denied would be covered under the Plan except for the Plan's determination that the treatment if experimental or investigational.

The External Review shall be conducted by an independent review organization assigned by the Ohio Department of Insurance.

You are not required to pay any part of the cost of the review. The cost of the review shall be borne by the Plan.

The independent review organization shall issue a written decision no later than 30 days (7 days for an expedited review) after the filing of the request for review.

The Plan shall provide any coverage determined by the independent review organization to be necessary, subject to the terms, limitations, and conditions of the plan.

For more information about the External Review process, call the toll-free Member Services telephone number shown on your ID card.

No Preexisting Condition Limitations for Members under age 19

The Preexisting Condition Limitations described in the Exclusion and Limitations Section of your Plan do not apply to members who are under 19 years of age. With respect to members who are under 19 years of age, your Plan covers any condition that may have been previously excluded by name or specific description as a pre-existing condition. This also means a member under the age of 19 cannot be excluded from the plan if the exclusion is based on a preexisting condition.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from us or any other person (including a primary care physician) 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 **Aetna** at the telephone number shown on your Member I.D. card.

Selection of a Primary Care Physician

We generally allow the designation of a primary care physician. You have the right to designate any primary care physician who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care physician.

For information on how to select a primary care physician, and for a list of the participating primary care physicians, call Member Services at the number shown on your I.D. card.

This Amendment takes effect on the later of the effective date of the Plan to which it is attached, or January 1, 2018. This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

IN WITNESS WHEREOF:

AETNA LIFE INSURANCE COMPANY
(A Stock Company)

Mark T. Bertolini
Chairman, Chief Executive Officer and President

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.

Additional Information Provided by

URS | CH2M Oak Ridge LLC (UCOR)

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Please see your Plan Administrator for this information.

Employer Identification Number:
45-2178216

Plan Number:
510

Type of Plan:
Group Welfare Benefit Plan

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Sponsor:
URS | CH2M Oak Ridge LLC (UCOR)
P.O. Box 4699
MS 7020, K-1007
Oak Ridge, TN 37831
865-576-9206

A complete list of employers and employee organizations sponsoring each plan may be obtained by participants and beneficiaries upon request to the Plan Administrator, and is available for examination by participants and beneficiaries by contacting the Plan Administrator. Further, participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the plan, and if the employer is a plan sponsor, the plan sponsor's address.

Plan Administrator:
The plan is administered through the Benefits and Investments Committee. The Committee has delegated day-to-day administration of the plan to:
URS | CH2M Oak Ridge LLC (UCOR)
P.O. Box 4699
MS 7020, K-1007
Oak Ridge, TN 37831
865-576-9206

Agent For Service of Legal Process:

CT Corporation Systems
800 South Gay Street, Suite 2021
Knoxville, TN 37929

CT Corporation Systems
Kentucky Home Life Building
Louisville, KY 40202

CT Corporation Systems
1300 East 9th Street
Cleveland, OH 44114

Service of legal process may also be made on the Plan Administrator or Plan Trustee.

***Plan Trustee*:**
Sun Trust Bank, East, TN-0547.
P.O. Box 4655
25 Park Place, MC 210
Atlanta, GA 30302

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by individual authorized by the Board of Directors of URS | CH2M Oak Ridge LLC (UCOR).

The Plan is maintained in accordance with health and welfare provisions of a collective bargaining agreement.

ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

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

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

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

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to recent changes to preventive services coverage and women's preventive health coverage under the Federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of the ACA.

The following is a summary of the recent changes to preventive services coverage and women's preventive health coverage under the ACA that applies to non-grandfathered plans that are not otherwise exempt from the requirements. Preventive services, as required by ACA, will be paid without cost-sharing such as payment percentages, copays and deductibles.

For details on any benefit maximums and the cost sharing under your plan, call the Member Services number on the back of your ID card.

1. An annual routine physical exam for covered persons through age 21.

2. For covered females:
   - Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
     - Screening and counseling services, such as:
       - Interpersonal and domestic violence;
       - Sexually transmitted diseases; and
       - Human Immune Deficiency Virus (HIV) infections.
     - Screening for gestational diabetes.
     - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once - three years.
   - A routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration.

3. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
   - Preventive counseling visits and/or risk factor reduction intervention;
   - Medical nutrition therapy;
   - Nutritional counseling; and
   - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

   Benefits under your plan may be subject to visit maximums.

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

   Benefits under your plan may be subject to visit maximums.

5. Screening and counseling services to aid you to stop the use of tobacco products. Coverage includes:
   - Preventive counseling visits;
   - Treatment visits; and
   - Class visits.

   Benefits under your plan may be subject to visit maximums.

6. Prenatal care received by a pregnant female. Coverage is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

7. Comprehensive lactation support, (assistance and training in breast feeding), and counseling services provided by a certified lactation support provider, in a group or individual setting, to females during pregnancy and in the post partum period.

   The rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk), and the purchase of the accessories and supplies needed to operate the item. Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

   Benefits under your plan may be subject to maximums.

8. For females with reproductive capacity, coverage includes:
   - FDA-approved contraceptive methods including certain FDA-approved generic drugs, implantable devices, sterilization procedures and patient education and counseling for women with reproductive capacity.
   - Counseling services provided by a physician in either a group or individual setting on contraceptive methods. Benefits may be subject to visit maximums.
   - Female voluntary sterilization procedures and related services and supplies including tubal ligation and sterilization implants. Coverage does not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.
   - FDA-approved female generic emergency contraceptive methods that are prescribed by your physician. The prescription must be submitted to the pharmacist for processing.

   Additional exemptions may apply to plans that are sponsored by religious employers or religious organizations and meet certain criteria which exempt the health plan from the federal requirement to provide coverage for contraceptive services.

   The drug list is subject to change. Visit "Medication Search" on your secure member website at www.aetna.com for the most up-to-date information on drug coverage for your plan.

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.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that for new plans on or after January 1, 2014, and for non-grandfathered plans that renew on a date on or after January 1, 2014, Aetna is administering medical and outpatient prescription drug coverage in compliance with the following applicable components of the ACA.

The following is a summary of the recent changes under the ACA.

For details on any benefit maximums and the cost sharing under your plan, log onto the Aetna website www.aetna.com, call the Member Services number on the back of your ID card, or refer to the Summary of Benefit and Coverage document you have received.

1. Subject to any allowed applicable age, family history and frequency guidelines for preventive services covered under the plan, (which may be in-network only for plans that use a provider network) the following services are included in those considered preventive:

    - Coverage of comprehensive lactation support and counseling, and the costs of renting or purchasing breastfeeding equipment extended for the duration of breastfeeding.
    - In accordance with the recommendations of the United States Preventive Services Task Force, and when prescribed by a physician:
        i. aspirin for men and women age 45 and over;
        ii. folic acid for women planning or capable of pregnancy;
        iii. routine iron supplementation for asymptomatic children ages 6 to 12 months;
        iv. vitamin D supplementation for men and women age 65 and older;
        v. fluoride supplementation for children from age 6 months through age 5;
        vi. genetic counseling, evaluation and lab tests for routine breast cancer susceptibility gene (BRCA) testing;
        vii. Food and Drug Administration (FDA) approved female over-the-counter contraceptives, and an office visit for contraceptive administration and/or removal of a contraceptive device

2. Any annual or lifetime dollar maximum benefit that applies to "Essential Health Benefits" (as defined by the ACA and included in the plan) no longer applies. Essential Health Benefits will continue to be subject to any coinsurance, copays, deductibles, other types of maximums (e.g., day and visit maximums), referral and certification rules, and any exclusions and limitations that apply to these types of covered medical expenses under your plan.

3. If your Plan includes a pre-existing condition limitation or exclusion provision, including one that may apply to transplant coverage, then this limitation or exclusion no longer applies.

4. If your Plan includes a waiting or probationary period, (the period of time that must pass before your coverage can become effective), this period of time cannot be greater than 90 days.

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 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 FMLA 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.

With respect to Kentucky Employees:

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal and/or State Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by the Family and Medical Leave Act of 1993 ("FMLA") or leave required by Kentucky Rev. Stat. § 337.015 for the reception of an adoptive child under the age of seven ("Kentucky Adoption Leave Statute") If your Employer grants you approved FMLA and/or Kentucky Adoption Leave Statute leave for a period in excess of the period required by FMLA or Kentucky Adoption Leave Statute, 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 approved FMLA and/or Kentucky Adoption Leave Statute leave in accordance with FMLA and/or the Kentucky Adoption Leave Statute, you may, during the continuance of such approved FMLA and/or Kentucky Adoption Leave Statute 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 have reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA and/or Kentucky Adoption Leave Statute 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 and/or Kentucky Adoption Leave Statute leave is terminated; or
- 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 and/or Kentucky Adoption Leave Statute 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 and/or Kentucky Adoption Leave Statute 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 approved FMLA and/or Kentucky Adoption Leave Statute 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 approved FMLA and/or Kentucky Adoption Leave Statute leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA and/or Kentucky Adoption Leave Statute leave is terminated, your coverage under the group contract will be in force as though you had continued active employment rather than going on an approved FMLA and/or Kentucky Adoption Leave statute leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA and/or Kentucky Adoption Leave Statute 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 and/or Kentucky Adoption Leave Statute 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 and/or Kentucky Adoption Leave Statute leave is terminated.

With respect to Ohio Employees:

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 the Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you 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 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 have 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; or
- 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 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 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 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.

With respect to Tennessee Employees:

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal and/or State Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by the Family and Medical Leave Act of 1993 (FMLA) or the Tennessee Maternity Leave Act ("TMLA"). If your Employer grants you approved FMLA and/or TMLA leave for a period in excess of the period required by FMLA or TMLA, 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 approved FMLA and/or TMLA leave in accordance with FMLA and/or TMLA, you may, during the continuance of such approved FMLA and/or TMLA 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 have reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA and/or TMLA 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 and/or TMLA leave is terminated; or
- 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 and/or TMLA 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 and/or TMLA 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 approved FMLA and/or TMLA 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 approved FMLA and/or TMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA and/or TMLA leave is terminated, your coverage under the group contract will be in force as though you had continued active employment rather than going on an approved FMLA and/or TMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA and/or TMLA 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 and/or TMLA 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 and/or TMLA leave is terminated.

Schedule of Benefits

(GR-9N-S-01-001-01 OH)

Employer: **URS | CH2M Oak Ridge LLC (UCOR)**

Group Policy Number: **GP-720018**

Issue Date: March 10, 2018
Effective Date: January 1, 2018
Schedule: 5A
Cert Base: 5

Open Access Managed Choice (Open Access PPO) - Active Salaried Employees. Active Bargaining Unit Employees at URS/CH2M Oak Ridge LLC, Four Rivers Nuclear Partnership LLC, Wastren Advantage, Inc. (as a participating subcontractor under Four Rivers Nuclear Partnership, LLC) - Plan A

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Open Access Plan *(GR-9N 11-005 OH)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$400	$1,000
Family Deductible*	$800	$2,000
Per Admission Copayment	$300 per admission	Not Applicable
Per Admission Deductible*	Not Applicable	$300 per admission

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan **deductible** and **copayments**.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $5,100.
- For **out-of-network** expenses: $13,200.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $10,200.
- For **out-of-network** expenses: $26,400.

Lifetime Maximum Benefit per person	Unlimited	Unlimited

(GR-9N 10-016 05)

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, and the remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Preventive Care		
Routine Physical Exams ***Office Visits***	100% per visit No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible**

(GR-9N 10-016 05)

Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card*
Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive months	1 visit	1 visit
Covered Persons age 65 and over: Maximum Visits per 12 consecutive months	1 visit	1 visit

(GR-9N S 10-016 04 NG OH)

Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit No **copay** or **deductible** applies. Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.*	60% per visit after Calendar Year **deductible** Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.*

Screening & Counseling Services ***Office Visits*** ***-Obesity and/or Healthy Diet*** ***-Misuse of Alcohol and/or Drugs*** ***-Use of Tobacco Products*** ***-Sexually Transmitted Infections*** ***-Genetic Risk for Breast and Ovarian Cancer*** *(GR-9N S 10-016 04 NG OH)*	100% per visit No **copay** or **deductible** applies.	60% per visits after Calendar Year **deductible**

Obesity and/or Healthy Diet Benefit Maximums		
Maximum Visits per 12 consecutive months *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* *****	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* *****

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.
(GR-9N S 10-016 04 NG OH)

Misuse of Alcohol and/or Drugs		
Maximum Visits per 12 consecutive months	5 visits*	5 visits*

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.
(GR-9N S 10-016 04 NG OH)

Use of Tobacco Products Maximum Visits per 12 consecutive months	8 visits*****	8 visits*****

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.
(GR-9N S 10-016 04 NG OH)

Sexually Transmitted Infections Benefit Maximums Maximum Visits per 12 consecutive months	2 visits*****	2 visits*****

Note:** ***In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.

Well Woman Preventive Visits ***Office Visits*** Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administration	100% per visit No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Well Woman Preventive Visits Maximum Visits per Calendar Year	1 visit	1 visit

Hearing Exam *(GR-9N-S-11-10-01)*	100% per exam No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**
Maximum exams per 24 month period	1 exam	1 exam
Hearing Aids	100% No Calendar Year **deductible** applies.	100% No Calendar Year **deductible** applies.
Hearing Supply Maximum per 36 month period *(GR-9N S-25-005 01)*	$500	$500

Routine Cancer Screening *(GR-9N S 10-016 04 NG OH)*		
Outpatient: **Baseline Mammogram**	100% per visit No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Maximum	One baseline mammogram for women age 35 but less than age 40.	One baseline mammogram for women age 35 but less than age 40.
Outpatient: **All Other Mammograms**	100% per visit No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**.
Maximum for women at age 40	1 mammogram per Calendar Year	1 mammogram per Calendar Year
Outpatient: All Other Routine Cancer Screenings	100% per visit No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**.
(GR-9N S 10-016 04 NG OH)		
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • 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; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Subject to any age; family history; and frequency guidelines as set forth in the most current: • 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; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*
Lung Cancer Screening Maximum	One screening every 12 months*.	One screening every 12 months*.
*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing of your Schedule of Benefits.		

Prenatal Care		
Office Visits *(GR-9N S 10-016 04 NG OH)*	100% per visit No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible.**

Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services *(GR-9N S 10-016 04 NG OH)*		
Lactation Counseling Services *Facility or Office Visits*	100% per visit No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible**

(GR-9N S 10-016 04 NG OH)

Lactation Counseling Services Maximum Visits per 12 consecutive months either in a group or individual setting	6* visits	Not Applicable

***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

(GR-9N S 10-016 04 NG OH)

Breast Pumps & Supplies	100% per item. No **copay** or **deductible** applies.	60% per item after Calendar Year **deductible**

Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.

(GR-9N S 10-016 04 NG OH)

Family Planning Services		
Female Contraceptive Counseling Services -Office Visits.	100% per visit. No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible**

(GR-9N S 10-016 04 NG OH)

Contraceptive Counseling Services - Maximum Visits per 12 consecutive months either in a group or individual setting	2* visits	Not Applicable

*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Family Planning Services - Female Contraceptives *(GR-9N S 10-016 04 NG OH)*

Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits.	100% per item. No **copay** or **deductible** applies.	60% per item after Calendar Year **deductible**

Family Planning Services - Female Voluntary Sterilization *(GR-9N S 10-016 04 NG OH)*

Inpatient	100% per admission. No **copay** or **deductible** applies.	60% per admission after Calendar Year **deductible**
Outpatient	100% per visit/surgical procedure. No **copay** or **deductible** applies.	60% per visit/surgical procedure after Calendar Year **deductible**

Family Planning – Other		
Voluntary Termination of Pregnancy		
Outpatient	80% per visit/surgical procedure after Calendar Year **deductible.**	60% per visit/surgical procedure after Calendar Year **deductible.**

Voluntary Sterilization for Males Outpatient	80% per visit/surgical procedure after Calendar Year **deductible.**	60% per visit/surgical procedure after Calendar Year **deductible.**

Preventive Care Drugs and Supplements	
Preventive care drugs and supplements filled at a retail **pharmacy** for each 30 day supply. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.	100% per item No **copay** or **deductible** applies.

Tobacco Cessation Prescription and Over-the-Counter Drugs	
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply. Maximums: Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.	100% per item No **copay** or **deductible** applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care *(GR-9N-S-11-020-01)*		
Eye Examinations including refraction	$60 exam **copay** then the plan pays 100%% No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**
Maximum Benefit per 24 consecutive month period	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services *(GR-9N 11-025 05 OH)*		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Specialist Office Visits	$60 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery		
Physician	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Specialist	$60 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Walk-In Clinics Non-Emergency Visit	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Administration of Anesthesia	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**
Allergy Testing and Treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	60% per visit after Calendar Year **deductible**
Allergy Injections	Payable in accordance with the type of expense incurred and the place where service is provided.	60% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Emergency Medical Services		
Hospital Emergency Facility and Physician	$200 **copay** per visit after the Calendar Year **deductible** then the plan pays 80%	$200 **deuctible** per visit after the Calendar Year **deductible** then the plan pays 80% See Important Note Below

Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **payment percentage)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered

Important Notice:
A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$75 **copay** per visit after the Calendar Year **deductible** then the plan pays 80%	60% per visit after Calendar Year **deductible**

Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.

Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	Not covered	Not covered

Important Notice:
A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic and Preoperative Testing *(GR-9N-11-035 01 OH)*		
Complex Imaging Services		
Complex Imaging	80% per test after Calendar Year **deductible**	60% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Surgery *(GR-9N-11-040-01 OH)*		
Performed in a Physician's Office	80% per visit **copay** after Calendar Year **deductible** then the plan pays 100%	60% per visit/surgical procedure after Calendar Year **deductible**
Performed at a Hospital Outpatient Facility	80% per visit **copay** after Calendar Year **deductible** then the plan pays 80%	60% per visit/surgical procedure after Calendar Year **deductible**
Performed at any other Facility	80% per visit **copay** after Calendar Year **deductible** then the plan pays 80%	60% per visit/surgical procedure after Calendar Year **deductible**
Maximum Benefit per surgical procedure at any Facility (Applies to Facility Fees only)	$300	Does Not Apply

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses *(GR-9N-11-045 01 OH)*		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	$300 per admission **deductible** after Calendar Year **deductible** then the plan pays 60%
Hospital Facility Expenses Room and Board (including maternity)	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$300 per admission **deductible** after Calendar Year **deductible** then the plan pays 60%
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$300 per admission **deductible** after Calendar Year **deductible** then the plan pays 60%
Maximum Days per Calendar Year	120 days	120 days

Important Notice:
The in-network hospital inpatient per confinement copay or the out-of-network hospital inpatient per confinement deductible applies once to all hospital confinements, regardless of cause, which are separated by less than 10 days, not counting the day of discharge of the prior confinement. The per confinement copay and per confinement deductible apply to any inpatient confinement, regardless of facility type.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits *(GR-9N-11-050-01 OH)*		
Home Health Care (Outpatient)	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	120 visits	120 visits
Skilled Nursing Care (Outpatient)	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**
Private Duty Nursing (Outpatient)	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**
Maximum Visit Limit per Calendar Year	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.

Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$300 per admission **deductible** after Calendar Year **deductible** then the plan pays 60%
Hospice Care - Other Expenses during a stay	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days

Important Notice:
The in-network hospital inpatient per confinement copay or the out-of-network hospital inpatient per confinement deductible applies once to all hospital confinements, regardless of cause, which are separated by less than 10 days, not counting the day of discharge of the prior confinement. The per confinement copay and per confinement deductible apply to any inpatient confinement, regardless of facility type.

Hospice Outpatient Visits	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment *(GR-9N S-11-55-01)*		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with type of expense incurred. Refer to the Physician Services and other sections of this Schedule to determine what the plan pays.	Payable in accordance with type of expense incurred. Refer to the Physician Services and other sections of this Schedule to determine what the plan pays.
Comprehensive Infertility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Artificial Insemination Maximum Benefit	6 courses of treatment per lifetime	6 courses of treatment per lifetime
Ovulation Induction Maximum Benefit	6 courses of treatment per lifetime	6 courses of treatment per lifetime

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders *(GR-9N-S-11-062-01)*		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$300 per admission **deductible** after Calendar Year **deductible** then the plan pays 60%
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$300 per admission **deductible** after Calendar Year **deductible** then the plan pays 60%
Inpatient Residential Treatment Facility Expenses Physician Services	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders		
Outpatient Services	$60 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$300 per admission **deductible** after the Calendar Year **deductible** then the plan pays 60%
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**

Inpatient Residential Treatment Facility Expenses	$300 per admission **copay** after Calendar Year **deductible**, then the plan pays 80%	$300 per admission **deductible** after Calendar Year **deductible**, then the plan pays 60%
Inpatient Residential Treatment Facility Expenses Physician Services	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

Outpatient Treatment of Substance Abuse		
Outpatient Treatment	$60 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK (IOE Facility)**	**NETWORK (Non-IOE Facility)**	**OUT-OF-NETWORK**
Transplant Services Facility and Non-Facility Expenses *(GR-9N S-11-065-01 OH) (GR-9N-11-080-01 OH)*			
Transplant Facility Expenses	$300 per admission **copay** after Calendar Year **deductible**, then the plan pays 80%	$300 per admission **copay** after Calendar Year **deductible**, then the plan pays 60%	$300 per admission **copay** after Calendar Year **deductible**, then the plan pays 60%
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	60% per visit after Calendar Year **deductible**.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Other Covered Health Expenses *(GR-9N-11-080-01 OH)*		
Acupuncture in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.	60% per visit after Calendar Year **deductible**
Ground, Air or Water Ambulance	80% after Calendar Year **deductible**	80% after Calendar Year **deductible**
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	60% per visit after Calendar Year **deductible**
Durable Medical and Surgical Equipment	80% per item after the Calendar Year **deductible**	60% per item after the Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) *(GR-9N-11-080-01 OH)*	Payable in accordance with the type of expense incurred and the place where service is provided.	60% per visit after Calendar Year **deductible**

Orthotic and Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	60% per visit after Calendar Year **deductible**
Clinical Trial Therapies *(GR-9N S 10-016 04 NG OH)* (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Routine Patient Costs	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies *(GR-9N S-11-090-01 OH)*		
Chemotherapy	80% after Calendar Year **deductible**	60% after Calendar Year **deductible**
Infusion Therapy	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Radiation Therapy	80% after Calendar Year **deductible**	60% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies *(GR-9N-11-095-01 OH)*		
Outpatient Physical, Occupational and Speech Therapy combined and Spinal Manipulation	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Combined Physical, Occupational and Speech Therapy and Spinal Manipulation Maximum visits per Calendar Year	60 visits	60 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder Treatment *(GR-9N S-10-061-07 OH)* Includes pharmacy coverage for treatment when a pharmacy plan is not elected by the contract holder.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.
Autism Spectrum Disorder Diagnosis and Testing	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.

Applied Behavior Analysis	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Physical Therapy Associated with Diagnosis of Autism Spectrum Disorder	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Visit limit per Calendar Year	Unlimited visits	Unlimited visits
Occupational Therapy Associated with Diagnosis of Autism Spectrum Disorder	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Visit limit per Calendar Year	Unlimited visits	Unlimited visits
Speech Therapy Associated with Diagnosis of Autism Spectrum Disorder	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Visit limit per Calendar Year	Unlimited visits	Unlimited visits
Maximum Applied Behavioral Analysis benefit including clinical therapeutic intervention.	Unlimited hours per week.	Unlimited hours per week.

Note: If the calendar year deductible is waived for a service or supply, you pay the copayment or coinsurance amount shown, above for the service or supply until the waiver amount is reached. After the waiver amount is reached, you are responsible to pay the calendar year deductible until it has been met

Pharmacy Benefit *(GR-9N-S-26-005-01)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Prescription Drug calendar year Deductible	\$100 Individual \$200 Family	\$100 Individual \$200 Family

Prescription Drug Calendar Year Deductible
The individual **prescription drug Calendar Year deductible** applies separately to you and each of your covered dependents. The family **prescription drug Calendar Year deductible** applies to you and your covered dependents combined. After **prescription drug covered expenses** reach the **prescription drug Calendar Year deductible**, the plan will begin to pay benefits for **networkprescription drug covered expenses** for the rest of the **Calendar Year**. The **prescription drug Calendar Year deductible** applies to **network and out-of-network retail prescription drug covered expenses** combined.

Copays/Deductibles *(GR-9N S-26-011 01) (GR-9N S-26-013 01) (GR-9N S-26-016 01)*

PER PRESCRIPTION COPAY/DEDUCTIBLE	**NETWORK**	**OUT-OF-NETWORK**
Preferred Generic Prescription Drugs		
For each initial 30 day supply filled at a retail **pharmacy**	30% copay up to a $150 maximum	30% copay up to a $150 maximum
	Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**	Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy**	30% copay up to a $300 maximum	Not Covered
Preferred Brand-Name Prescription Drugs		
For each initial 30 day supply filled at a retail **pharmacy**	30% copay up to a $150 maximum	30% copay up to a $150 maximum
	Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**	Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy**	30% copay up to a $300 maximum	Not Covered
Non-Preferred Generic Prescription Drugs		
For each initial 30 day supply filled at a retail **pharmacy**	30% copay up to a $150 maximum	30% copay up to a $150 maximum
	Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**	Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy**	30% copay up to a $300 maximum	Not Covered
Non-Preferred Brand-Name Prescription Drugs		
For each initial 30 day supply filled at a retail **pharmacy**	30% copay up to a $300 maximum	30% copay up to a $300 maximum
	Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**	Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy**	30% copay up to a $600 maximum	Not Covered

Preferred Self-injectable Prescription Drugs		
For each 30 day supply	30% of the negotiated charge not to exceed a $400 maximum	Not Covered
Non-preferred Self-injectable Prescription Drugs		
For each 30 day supply	30% of the negotiated charge not to exceed a $400 maximum	Not Covered

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If you request a covered brand-name **prescription drug** where a **generic prescription drug** equivalent is available you will be responsible for the cost difference between the **brand-name prescription drug** and the **generic prescription drug** equivalent, plus the applicable cost sharing.

(GR-9N S 26-023 02 NG OH)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
FDA-Approved Female Generic Over-the-Counter Contraceptives For each 30 day supply filled at a retail **pharmacy**	100% per supply No **copay** or **deductible** applies.	Not covered.
FDA-Approved Female Generic Emergency Over-the-Counter Contraceptives	100% per supply No **copay** or **deductible** applies.	Not covered.

Important Note:
This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the Aetna website at www.aetna.com or calling the toll-free number on the back of the ID card.

Preventive Care Drugs and Supplements *(GR-9N S26-024-01 NG OH)*		
Preventive care drugs and supplements filled at a **pharmacy** with a **prescription**: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.	100% per item. No **copay** or **deductible** applies.	Not Covered.

Important Note:
Refer to the Booklet and the *Preventive Care* section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.

Tobacco Cessation Prescription and Over-the-Counter Drugs *(GR-9N 26-024 01 OH)* Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply. Maximums: Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.	100% per supply No **copay** or **deductible** applies.	Not Covered.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	60% of the **recognized charge**

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Precertification for certain prescription drugs is required. If precertification is not obtained, the prescription drug will not be covered.

Prescription Drug Coinsurance Limit

	NETWORK	OUT-OF-NETWORK
Prescription Drug Calendar Year Coinsurance	$1,500 Individual $3,000 Family	$1,500 Individual $3,000 Family

Individual Prescription Drug Coinsurance Limit: Your plan has limitations set for what you are expected to contribute. Your plan will pay benefits for **prescription drug covered expenses**, as follows:

Network Prescription Drug Coinsurance Limit:
When your share or your covered dependent's share of **network prescription drug covered expenses** reach the **prescription drug network Coinsurance Limit** in a Calendar Year, your plan will pay 100% of that person's **network prescription drug covered expenses** for the rest of the Calendar Year.

Family Prescription Drug Coinsurance Limit: Your plan has limitations set for what your family is expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

Out-of-Network Prescription Drug Coinsurance Limit:
When your share and your covered dependents share of **network prescription drug covered expenses** combined reach the family **network prescription drug Coinsurance Limit** in a Calendar Year, your plan will pay 100% of the family's **network prescription drug covered expenses** for the rest of the Calendar Year.

Network Prescription Drug Maximum Out-of-Pocket Limit
When your share or your covered dependent's share of **network prescription drug covered expenses** reach the **prescription drug network Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of that person's **network prescription drug covered expenses** for the rest of the calendar year.

Out-Of-Network Prescription Drug Maximum Out-of-Pocket Limit
When your share or your covered dependent's share of **out-of-network prescription drug covered expenses** reach the **out-of-network prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of that person's **out-of-network prescription drug covered expenses** for the rest of the calendar year.

Family Prescription Drug Maximum Out-of-Pocket Limit. Your plan has limitations set for what your family is expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

Network Prescription Drug Maximum Out-of-Pocket Limit
When your share and your covered dependents share of **network prescription drug covered expenses** combined reach the family **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of the family's **network prescription drug covered expenses** for the rest of the calendar year.

Out-Of-Network Prescription Drug Maximum Out-of-Pocket Limit
When your share and your covered dependents share of **out-of-network prescription drug covered expenses** combined reach the family **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of the family's **out-of-network prescription drug covered expenses** for the rest of the calendar year.

Excluded Covered Expenses
Certain **prescription drug covered expenses** do not apply toward your individual **prescription drug** coinsurance limit and the family prescription **drug** coinsurance limit. These include:

Expenses applied toward a deductible or copay amount.
Expenses above the **recognized charge**.
Expenses incurred because you failed to obtain any necessary **precertification**.
Non-**covered expenses**.

Precertification for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

Expense Provisions *(GR-9N-S-09-05-01 OH)*

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Deductible Provisions *(GR-9N-S-09-05-01 OH)*

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

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

Covered expenses applied to the **out-of-network deductible** will not be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will not be applied to satisfy the **out-of-network deductible**.

Network Family Deductible Limit
When you incur **network covered expenses** that apply toward the **network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **network** Calendar Year family **deductible** limit. Your **network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **network** family **deductible** limit in a Calendar Year.

Out-of-Network Family Deductible Limit
When you incur **out-of-network covered expenses** that apply toward the **out-of-network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **out-of-network** Calendar Year family **deductible** limit. Your **out-of-network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **out-of-network** family **deductible** limit in a Calendar Year.

Covered expenses applied to the **out-of-network deductible** will not be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will not be applied to satisfy the **out-of-network deductible**.

Copayments and Benefit Deductible Provisions *(GR-9N-S-09-015-01 OH)*

Copayment, Copay
This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

Per Admission Deductible
A Per Admission **Deductible** is a specified dollar amount for which no benefit is paid when you or a covered dependent have a **stay** in an inpatient facility.

Separate **deductibles** may apply per facility. These **deductibles** are in addition to any other **deductible** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

Covered expenses applied to the per admission **deductible** cannot be applied to any other or **deductible** required in your plan. Likewise, **covered expenses** applied to your plan's other **deductibles** cannot be applied to meet the per admission **deductible**.

For the stay of a well newborn baby (starting at birth), the per admission **deductible** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

Per Admission Copayment
A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

Covered expenses applied to the per admission **copayment** cannot be applied to any other **copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **copayments** cannot be applied to meet the per admission **copayment**.

For the stay of a well newborn baby (starting at birth), the per admission **copayment** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

Coinsurance Provisions *(GR-9N S-09-020 01)*

Coinsurance
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "**Plan Coinsurance**". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The **coinsurance** percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

Maximum Out-of-Pocket Limit
The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Maximum Out-of-Pocket Limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Maximum Out-of-Pocket Limit** applies to network benefits.

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

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

The **Maximum Out-of-Pocket Limit** applies to both network and out -of-network benefits. You have separate **Maximum Out-of-Pocket Limits** for in-network and out-of-network benefits. **Maximum Out-of-Pocket Limit** amounts paid by you for in-network and out -of-network **covered expenses** apply to each limit separately and may not be combined and applied toward one limit.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction *(GR-9N S-09-30 01-OH)*

The Booklet-Certificate contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A $400 benefit reduction will be applied separately to each type of expense.

General *(GR-9N-28-01-01-OH)*

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.

BENEFIT PLAN

Prepared Exclusively For
URS | CH2M Oak Ridge LLC (UCOR)

Open Access Managed Choice - Consumer Directed Health Plan Qualified High Deductible Health Plan (HDHP) - All Active Participating Employers and Eligible Employees - Plan CDHP

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℠

Table of Contents

*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface *(GR-9N-02-005-01 OH)*

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Group Policyholder:	URS | CH2M Oak Ridge LLC (UCOR)
Group Policy Number:	GP-720018
Effective Date:	January 1, 2018
Issue Date:	March 10, 2018
Booklet-Certificate Number:	6

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage *(GR-9N-02-020-01 OH)*

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an accident, **injury** or **illness** that occurred, began or existed while coverage was in effect.

Please refer to the sections, "*Termination of Coverage (Extension of Benefits)*" and "*Continuation of Coverage*" for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

Coverage for You and Your Dependents *(GR-9N-02-020-01 OH)*

Health Expense Coverage *(GR-9N-02-020-01 OH)*

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet-Certificate* for more information about your coverage.

Treatment Outcomes of Covered Services *(GR-9N-02-020-01 OH)*

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Can Be Covered

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class", as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are considered an eligible employee as defined in the URS|CH2M Oak Ridge LLC (UCOR) Summary Plan Description. Aetna will rely on the representation of the employer as to a person's eligibility for coverage under the plan and as to any fact concerning such eligibility.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents *(GR-9N 29-010 01)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Dependent Children *(GR-9N-S-29-005-02-OH)*

To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Important Reminder
Keep in mind that you cannot receive coverage under this Plan as:

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

How and When to Enroll *(GR-9N 29-015-02)*

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Late Enrollment

If you do not enroll during the Initial Enrollment Period, or a subsequent annual enrollment period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next annual enrollment period. If, at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must return your completed enrollment form before the end of the next annual enrollment period.

However, you and your eligible dependents may not be considered **Late Enrollees** under the circumstances described in the "Special Enrollment Periods" section below.

Annual Enrollment *(GR-9N 29-015-HRPA OH)*

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Special Enrollment Periods *(GR-9N-29-015-05)*

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You or your dependents were covered under other **creditable coverage**; and
  - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other **creditable coverage**; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death;
  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - The employer's decision to stop offering the group health plan to the eligible class to which you belong;
  - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
  - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; or
  - You or your dependents have reached the lifetime maximum of another Plan for all benefits under that Plan.
- You or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

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

- 31 days of when other **creditable coverage** ends;
- within 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- within 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of termination of **creditable coverage** must be provided to **Aetna**. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents
You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to **Aetna** within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child
Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement;
- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment;
- Any coverage limitations for a preexisting condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage;

When You Receive a Qualified Child Support Order
A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a preexisting condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

When Your Coverage Begins *(GR-9N-29-025-01 OH)*

Your Effective Date of Coverage
If you have met all the eligibility requirements, your coverage takes effect on the later of:

- The date you are eligible for coverage; or
- The date your enrollment form is received; and

- The date your required contribution is received by **Aetna**.

If your completed enrollment information is not received within 31 days of your eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Important Notice:
You must pay the required contribution in full.

Your Dependent's Effective Date of Coverage *(GR-9N 29-025-02)*

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

Note: New dependents need to be reported to **Aetna** within 31 days because they may affect your contributions. If you do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Retired Employees

In lieu of corresponding rules which apply to employees:

- If any health expense benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when health expense insurance ends will also apply to you.

How Your Medical Plan Works

(GR-9N-S-08-05-01 OH)

Common Terms

Accessing Providers

Precertification

It is important that you have the information and useful resources to help you get the most out of your **Aetna** medical plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Important Notes

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this Booklet-Certificate as **covered expenses** that are **medically necessary**.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this Booklet-Certificate in a safe place for future reference.

Common Terms *(GR-9N-08-010-01)*

Many terms throughout this Booklet-Certificate are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your Open Access Plan *(GR-9N-08-020-01 OH)*

This Preferred Provider Organization Open Access plan provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your Open Access plan, you can directly access any **physician**, **hospital** or **other health care** provider (**network** or **out-of-network**) for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through **network providers** or **out-of-network providers**.

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

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

deductibles, **copayments**, and payment percentage will generally be lower when you use participating **network providers** and facilities.

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

Availability of Providers

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

Ongoing Reviews

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

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

How Your Open Access Plan Works *(GR-9N 08-030-02)*

The Primary Care Physician: *(GR-9N 08-030-02)*

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

You may search online for the most current list of participating providers in your area by using DocFind, **Aetna**'s online provider directory at www.aetna.com. You can choose a **PCP** based on geographic location, group practice, medical specialty, language spoken, or **hospital** affiliation. DocFind is updated several times a week. You may also request a printed copy of the provider directory through your policyholder or by contacting Member Services through e-mail or by calling the toll free number on your ID card.

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

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

Changing Your PCP

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

Specialists and Other Network Providers

You may directly access **specialists** and **other health care** professionals in the network for covered services and supplies under this Booklet-Certificate. Refer to the **Aetna provider directory** to locate network **specialists**, **providers** and **hospitals** in your area. Refer to the *Schedule of Benefits* section for benefit limitations and out-of-pocket costs applicable to your plan.

Important Note
ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care **providers**. If you have not received your ID card or if your card is lost or stolen, notify **Aetna** immediately and a new card will be issued.

Accessing Network Providers and Benefits *(GR-9N 08-040-01)*

- You may select a **PCP** or other direct access **network provider** from the **network provider directory** or by logging on to **Aetna**'s website at www.aetna.com. You can search **Aetna**'s online **directory**, DocFind, for names and locations of **physicians** and **other health care** providers and facilities. You can change your **PCP** at anytime.
- If a service you need is covered under the plan but not available from a **network provider** or **hospital** in your area, please contact Member Services by email or at the toll-free number on your ID card for assistance.
- Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there are no additional out-of-pocket costs to you as a result of a **network provider's** failure to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- You will not have to submit medical claims for treatment received from network health care professionals and facilities. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** or facility less any cost sharing required by you. You will be responsible for **deductibles**, **coinsurance** and **copayments**, if any.

  You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **copayments**, or **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits *(GR-9N 08-045-01)*

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

- **Network providers** have agreed to accept the **negotiated charge**. **Aetna** will reimburse you for a **covered expense,** incurred from a **network provider,** up to the **negotiated charge** and the maximum benefits under this Plan, less any cost sharing required by you such as **deductibles**, **copayments** and **payment percentage**. Your **payment percentage** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.
- You must satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- **Deductibles** and **payment percentage** are usually lower when you use **network providers** than when you use **out-of-network providers.**

- For certain types of services and supplies, you will be responsible for any **copayments** shown in the *Schedule of Benefits*.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Schedule of Benefits* section for information on what expenses do not apply. Refer to your *Schedule of Benefits* for the specific **maximum out-of-pocket limit** amounts that apply to your plan.

- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or Sch*edule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.
- You may be billed for any **deductible**, **copayment**, or **coinsurance** amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits *(GR-9N 08-045-01)*

You have the choice to access licensed **providers**, **hospitals** and facilities outside the network for covered benefits. Your out-of-pocket costs, such as **deductibles** and **coinsurance**, are usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan. **Aetna** will only pay up to the **recognized charge**.

- You select a health care provider or facility for covered benefits.
- **Precertification** is necessary for certain services. When you receive services from an **out-of-network provider**, you are responsible for obtaining the necessary **precertification** from **Aetna**. Your provider may **precertify** your treatment for you, however you should verify with **Aetna** prior to the procedure, that the provider has obtained **precertification** from **Aetna**. If your treatment is not **precertified**, the benefit payable may be significantly reduced. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- When you use **physicians** and **hospitals** that are not in the network you may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an **out-of-network provider**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required of you by your plan.
- If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Important Note
Failure to **precertify** will result in a reduction of benefits under this Booklet-Certificate. Please refer to the *Understanding Precertification* section of this Booklet-Certificate for information on how to **precertify**.

Cost Sharing for Out-of-Network Benefits *(GR-9N 08-045-01)*

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

- **Out-of-network providers** have not agreed to accept the **negotiated charge. Aetna** will reimburse you for a **covered expense,** incurred from an **out-of network provider**, up to the **recognized charge** and the maximum benefits under this Plan, less any cost-sharing required by you such as **deductibles** and **payment percentage.** The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from an **out-of-network provider**. Your **payment percentage** is based on the **recognized charge**. If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. Except for emergency services, **Aetna** will only pay up to the **recognized charge**.
- You must satisfy any applicable **deductibles** before the plan begins to pay benefits.
- **Deductibles** and **payment percentage** are usually higher when you use **out-of network providers** than when you use **network providers.**

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

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

Understanding Precertification *(GR-9N-08-060 01)*

Precertification

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

You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from **Aetna** for any services or supplies on the **precertification** list below. If you do not **precertify**, your benefits may be reduced, or the plan may not pay any benefits. The list of services requiring **precertification** follows on the next page.

Important Note
Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

The Precertification Process

Prior to being **hospitalized** or receiving certain other medical services or supplies there are certain **precertification** procedures that must be followed.

You are responsible for obtaining **precertification**. You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission or medical services and expenses prior to receiving any of the services or supplies that require **precertification** pursuant to this Booklet-Certificate in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call **Aetna** at the telephone number listed on your ID card. This call must be made:

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

Aetna will provide a written notification to you and your **physician** of the **precertification** decision. If your **precertified** expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

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

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna's** decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the Appeals Amendment included with this Booklet-Certificate.

Services and Supplies Which Require Precertification *(GR-9N 08-065 05 OH)*

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital**;
- **Stays** in a **skilled nursing facility**;
- **Stays** in a **rehabilitation facility**;
- **Stays** in a **hospice** facility;
- Outpatient **hospice care**;
- **Stays** in a **Residential Treatment Facility**;
- **Partial Hospitalization Programs**;
- **Home health care**;
- Private duty nursing care;
- Intensive Outpatient Programs;
- Applied Behavioral Analysis;
- Neuropsychological testing;
- Outpatient detoxification;
- Psychological testing;
- Transcranial magnetic stimulation (TMS).

How Failure to Precertify Affects Your Benefits *(GR-9N 08-070-01)*

A **precertification** benefit reduction will be applied to the benefits paid if you fail to obtain a required **precertification** prior to incurring medical expenses. This means **Aetna** will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary **precertification** from **Aetna** prior to receiving services from an **out-of-network provider**. Your provider may **precertify** your treatment for you; however you should verify with **Aetna** prior to the procedure, that the provider has obtained **precertification** from **Aetna**. If your treatment is not **precertified** by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered.

How Your Benefits are Affected

The chart below illustrates the effect on your benefits if necessary **precertification** is not obtained.

If **precertification** is:	then the expenses are:
▪ requested and approved by **Aetna**	▪ covered.
▪ requested and denied.	▪ not covered, may be appealed.
▪ not requested, but would have been covered if requested.	▪ covered after a **precertification** benefit reduction is applied.*
▪ not requested, would not have been covered if requested.	▪ not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your **precertification** requirement was not met will not count toward your **deductible, coinsurance limit** or **maximum out of pocket limit**.

*Refer to the *Schedule of Benefits* section for the amount of **precertification** benefit reduction that applies to your plan.

Emergency and Urgent Care *(GR-9N-27-005-01)*

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

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

In Case of a Medical Emergency

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

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **primary care physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **PCP** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **PCP** as soon as reasonably possible.

- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur. Please refer to the *Schedule of Benefits* for specific details about the plan. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the plan.

Coverage for Emergency Medical Conditions

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

Important Reminder
If you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the Plan.

In Case of an Urgent Condition *(GR-9N-27-010-01 OH)*

Call your **PCP** if you think you need urgent care. **Network providers** are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any **physician**, in- or out-of-network, for an **urgent care condition** if you cannot reach your **physician**.

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

Coverage for an Urgent Condition

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

Non-Urgent Care

If you seek care from an **urgent care provider** for a non-**urgent condition**, (one that does not meet the criteria above), the plan will not cover the expenses you incur unless otherwise specified under the Plan. Please refer to the *Schedule of Benefits* for specific plan details.

Important Reminder
If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-urgent care received at a hospital or an urgent care provider unless otherwise specified.

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

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

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

To keep your out-of-pocket costs lower, your follow-up care should be accessed through your **PCP**.

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

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

Requirements for Coverage *(GR-9N-09-005-01 OH)*

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

1. The service or supply or **prescription drug** must be covered by the plan. For a service or supply or **prescription drug** to be covered, it must:

   - Be included as a covered expense in this Booklet-Certificate;
   - Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet-Certificate for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.

2. The service or supply or **prescription drug** must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply or **prescription drug** must be **medically necessary**. To meet this requirement, the medical services, supply or **prescription drug** must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

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

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

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

What The Plan Covers

(GR-9N 11-005 OH)

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

Open Access Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

Preventive Care *(GR-9N 11-006 07 OH)*

This section on Preventive Care describes the **covered expenses** for services and supplies provided when you are well.

Important Notes:

1. The recommendations and guidelines of the:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
   - United States Preventive Services Task Force;
   - Health Resources and Services Administration; and
   - American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents;

   as referenced throughout this Preventive Care section may be updated periodically. This Plan is subject to updated recommendations or guidelines that are issued by these organizations beginning on the first day of the plan year, one year after the recommendation or guideline is issued.

2. If any diagnostic x-rays, lab, or other tests or procedures are ordered, or given, in connection with any of the Preventive Care benefits described below, those tests or procedures will not be covered as Preventive Care benefits. Those tests and procedures that are **covered expenses** will be subject to the cost-sharing that applies to those specific services under this Plan.

3. Gender-Specific *Preventive Care* Benefits — **covered expenses** include any recommended *Preventive Care* benefits described below that are determined by your provider to be **medically necessary**, regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. Refer to the Schedule of Benefits for information about cost-sharing and maximums that apply to Preventive Care benefits. **The Preventive Care benefits described below are not subject to cost-sharing.**

Two links to websites that discuss mandated preventive care benefits are attached here for your reference:

http://www.cdc.gov/vaccines/acip/index.html

http://www.healthcare.gov/center/regulations/prevention.html

Routine Physical Exams *(GR-9N 11-006 04 NG OH)*

Covered expenses include charges made by your **primary care physician (PCP)**, for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical 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 Guidelines for Children and Adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.
  - Screening for gestational diabetes for women.
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** check up.

Child Health Supervision Services

Covered expenses include charges for the periodic review of a child's physical and emotional status performed by a **physician** for a child from birth to age 9.

A periodic review is a review performed in accordance with the recommendations of the American Academy of Pediatrics and includes:

- A review and written record of the child's complete medical history.
- Taking measurements and blood pressure.
- Anticipatory guidance.
- Development and behavioral assessment.
- Hearing screening.
- Vision and lead toxicity screening and immunizations.
- One series of hereditary and metabolic tests performed at birth.
- Urinalysis and blood tests such as hematocrit and hemoglobin tests.
- Counseling and guidance of the child and the child's parents or guardians on the results of the physical exam.

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

- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit);
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Routine Cancer Screenings *(GR-9N 11-006 04 NG OH)*

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;

- Double contrast barium enemas (DCBE); and
- Colonoscopies (removal of polyps performed during a screening procedure is a **covered expense**).
- Lung cancer screening

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; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Although not included in the guidelines recommended by the United States Preventive Services Task Force or the guidelines supported by the Health Resources and Services Administration, the Plan also covers one baseline mammogram for a woman age 35 but less than age 40.

The total payment billed by a **provider** for a screening mammogram, including your cost sharing, cannot exceed 130% of the Medicare reimbursement amount for a screening mammogram. Only a baseline screening mammogram for women between the ages of 35 and 40 is subject to cost sharing. All other required screening mammograms are paid at 100% of billed charges.

Exclusions:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:
- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit).

Important Notes:
1. Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Preventive Care.
2. For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your **physician** or **Member Services** by logging onto the **Aetna** website www.aetna.com or calling the number on the back of your ID card.

Preventive Care Immunizations *(GR-9N 11-006 07 OH)*

Covered expenses include charges made by your **physician** or a facility for:
- immunizations for infectious diseases; and
- the materials for administration of immunizations;

that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Limitations:
Not covered under this Preventive Care benefit are charges incurred for:
- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit); and
- Immunizations that are not considered Preventive Care such as those required due to your employment or travel.

Well Woman Preventive Visits *(GR-9N 11-006 07 OH)*
Covered expenses include charges made by your **physician**, obstetrician, or gynecologist for:
- a routine well woman preventive exam office visit, including Pap smears/cytologic screening. A routine well woman preventive 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

- routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. **Covered expenses** include charges made by a **physician** and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

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; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Exclusions:
Unless specified above, not covered under this Preventive Care benefit are charges for:
- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit);
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Screening and Counseling Services *(GR-9N 11-006 07 OH)*

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

Obesity and/or Healthy Diet
Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
- Preventive counseling visits and/or risk factor reduction intervention;
- Nutritional counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

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

Use of Tobacco Products
Screening and counseling services to aid you to stop the use of tobacco products.

Coverage includes:
- Preventive counseling visits;
- Interventions;
- Treatment visits; and
- Class visits;

to aid you to stop the use of tobacco products.

Coverage includes the following, without any requirement for pre-authorization for treatment:
- 4 sessions of individual, group and phone counseling;
- 90 days of FDA-approved smoking cessation medications; and
- 2 quit attempts per year.

Tobacco product means a substance containing tobacco or nicotine including:
- Cigarettes;
- Cigars;
- Smoking tobacco;
- Snuff;
- Smokeless tobacco; and

- Candy-like products that contain tobacco.

Sexually Transmitted Infections
Covered expenses include the counseling services to help you prevent or reduce sexually transmitted infections.

Genetic Risks for Breast and Ovarian Cancer
Covered expenses include the counseling and evaluation services to help you assess your risk of breast and ovarian cancer susceptibility.

Benefits for the screening and counseling services above are subject to any visit maximums shown in your *Schedule of Benefits***.**

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for:
- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit).

Prenatal Care *(GR-9N 11-006 04 NG OH)*
Prenatal care will be covered as Preventive Care for services received by a pregnant female in a **physician's**, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check and fundal height).

Exclusions:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:
- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under the diagnostic testing benefit); and
- Pregnancy expenses (other than prenatal care as described above).

Important Notes:
Refer to the Pregnancy Expenses and Exclusions sections of this Booklet-Certificate for more information on coverage for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services *(GR-9N 11-006 04 NG OH)*
Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breast-feeding by a certified lactation support provider. **Covered expenses** also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your Schedule of Benefits**.**

Breast Feeding Durable Medical Equipment
Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pump
Covered expenses include the following:
- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.
- The purchase of:

- An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
- A manual breast pump. A purchase will be covered once per pregnancy.

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

Breast Pump Supplies
Coverage is limited to only one breast pump purchase per pregnancy.

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

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Exclusions:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

• Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test will be payable under a diagnostic testing benefit).

Family Planning Services - Female Contraceptives *(GR-9N 11-006 04 NG OH)*

For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **covered expenses** when provided in either a group or individual setting. They are subject to the contraceptive counseling services visit maximum shown in your Schedule of Benefits**.**

The following contraceptive methods are **covered expenses** under this Preventive Care benefit:

(GR-9N 11-006 04 NG OH)
Voluntary Sterilization
Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered expenses under this Preventive Care benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

Contraceptives *(GR-9N 11-006 04 NG OH)*
Contraceptives can be paid either under your medical plan or **pharmacy** plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive p**rescription drugs** and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit. For a list of the types of female contraceptives covered under this Plan, refer to the What the Pharmacy Plan Covers section and the Contraceptives benefit later in this Booklet-Certificate.

Important Note:
For a list of the types of female contraceptives covered under this Plan, refer to the section What the Pharmacy Plan Covers and the Contraceptives benefit later in this Booklet-Certificate.

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

- Services which are not preventive care and are covered to any extent under any other part of this Plan (for example: a diagnostic test is payable under the diagnostic testing benefit);
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
- Services which are for the treatment of an identified **illness** or **injury**;
- Services that are not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices; and
- The reversal of voluntary sterilization procedures, including any related follow-up care.

Family Planning Services – Other *(GR-9N 11-006 04 NG OH)*

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

- Voluntary sterilization for males
- Voluntary termination of pregnancy

Exclusions:

Not covered under this **Family Planning Services – Other** benefit are:

- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your Policyholder; and
- Charges incurred for Family Planning Services-Other benefits while confined as an inpatient in a **hospital** or other facility.

Important Notes:

1. Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Family Planning Services - Other.
2. For more information, see the sections on Family Planning Services - Female Contraceptives, Pregnancy Expenses and Treatment of Infertility in this Booklet-Certificate.

Vision Care Services *(GR-9N 11-010-01 OH)*

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- ***Routine*** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 24 consecutive month period.

Limitations

Coverage is subject to any applicable Calendar Year **deductibles**, **copays** and **coinsurance** percentages shown in your *Schedule of Benefits.*

Hearing Exam *(GR-9N 11-015-01)*

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

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

The plan will not cover expenses for charges for more than one hearing exam for any 24-month period.

All **covered expenses** for the hearing exam are subject to any applicable **deductible**, **copay** and **coinsurance** shown in your *Schedule of Benefits*.

Physician Services *(GR 9N S 11-20 06)*

Physician Visits

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

Important Note:
All in-person office visits covered with a **behavioral health provider** are also covered if you use **telemedicine** instead.

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

Covered expenses also include:

- Immunizations for infectious disease;
- Allergy testing and allergy injections; and
- Charges made by the **physician** for supplies, x-rays, and tests provided by the **physician**.

Important Note:
For a description of the preventive care expenses covered under this Plan, refer to the *Preventive Care Benefits* section in this Booklet-Certificate.

Surgery

Covered expenses include charges made by a **physician** for:

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

Anesthetics

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

Important Note:

Certain procedures need to be **precertified** by **Aetna**. Refer to the *How the Plan Works* section of this Booklet-Certificate for more information about **precertification**.

Alternatives to Physician Office Visits *(GR-9N 11-020 02)*

Walk-In Clinic Visits

Covered expenses include charges made by **walk-in clinics** for:
Unscheduled, non-emergency illnesses and injuries; and the administration of certain immunizations administered within the scope of the clinic's license.

E-Visits
Covered expenses include charges made by your **physician** for a routine, non-emergency, medical consultation. You must make your **E-visit** through an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.Aetna.com or by calling the number on your identification card.

Hospital Expenses *(GR-9N-S-11-030-05 OH)*

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

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

Room and board charges also include:

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

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

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

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

Outpatient Hospital Expenses *(GR-9N-S-11-030-05 OH)*
Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

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

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

Hospital admissions need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

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

Refer to the *Schedule of Benefits* for details about any applicable **deductible**, **copay** and **coinsurance** and maximum benefit limits.

Coverage for Emergency Medical Conditions *(GR-9N-11-035 01 OH)*

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

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

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

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

Coverage for Urgent Conditions *(GR-9N-11-035 01 OH)*

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

Your coverage includes:

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

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

If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*.

Alternatives to Hospital Stays *(GR-9N-11-040-01 OH)*

Outpatient Surgery and Physician Surgical Services

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

- A **physician** or **dentist** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

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

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

The following outpatient surgery expenses are covered:

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

Limitations
Not covered under this plan are charges made for:

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

Birthing Center *(GR-9N-11-045 01 OH)*
Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.
- Longer stays require precertification.

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

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Pregnancy Related Expenses* for information about other **covered expenses** related to maternity care.

Home Health Care *(GR-9N-11-050-05 OH)*
Covered expenses include charges for home health care services when ordered by a **physician** as part of a home health plan and provided you are:

- Transitioning from a **hospital** or other inpatient facility, and the services are in lieu of a continued inpatient **stay**; or
- **Homebound**

Covered expenses include only the following:

- **Skilled nursing services** that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a **hospital** or **skilled nursing facility** after an inpatient **stay**, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous **skilled nursing services**. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.

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

In figuring the Calendar Year Maximum Visits, each visit of a:

- Nurse or Therapist, up to 4 hours is one visit.

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

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

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

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

Note: Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed in the Short Term Rehabilitation Therapies section of the *Schedule of Benefits*.

Limitations

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

- Services or supplies that are not a part of the **Home Health Care Plan**.
- Services of a person who usually lives with you, or who is a member of your or your spouse's family.
- Services of a certified or licensed social worker.
- Services for physical, occupational and speech therapy. Refer to Short Term Rehabilitation Therapies section for coverage information.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are **custodial care**.

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

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

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

Skilled Nursing Care *(GR-9N S-11-065-01 OH)*

Covered expenses include charges by an **R.N.**, **L.P.N.**, or nursing agency for outpatient skilled nursing care.

This is care by a visiting **R.N.** or **L.P.N.** to perform specific skilled nursing tasks.

Covered expenses also include private duty nursing provided by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing care and visiting nursing care is not adequate. However, **covered expenses** will not include private duty nursing for any shifts during a Calendar Year in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Limitations

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

- Nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a **R.N.** or **L.P.N.** to administer medicines.

Skilled Nursing Facility *(GR-9N-11-060-01 OH)*

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

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

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable **skilled nursing facility** maximums.

Admissions to a **skilled nursing facility** must be **precertified** by **Aetna**. Refer to *How Your Medical Plan Works* for details about **precertification**.

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

- Charges made for the treatment of:
  - Drug addiction;
  - Alcoholism;
  - Senility;
  - Mental retardation; or
  - Any other mental illness; and
- Daily **room and board** charges over the **semi-private rate**.

Hospice Care *(GR-9N S-11-070-01 OH)*
Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses
The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

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

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

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

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

- Medical supplies;
- **Prescription drugs**;
- Psychological counseling; and
- Dietary counseling.

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

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

Important Reminders
Refer to the *Schedule of Benefits* for details about any applicable **hospice care** maximums.

Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

Other Covered Health Care Expenses *(GR-9N-11-080-01 OH)*

Acupuncture
The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed:

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

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.

Ambulance Service *(GR-9N-11-080-01 OH)*
Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance
Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

Air or Water Ambulance

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

- Ground **ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **hospital** to another **hospital**; when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**; and the two conditions above are met.

Exclusions

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

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service; or
- By fixed wing air ambulance from an **out-of-network provider**.

Autism Spectrum Disorders *(GR-9N-11-171-06 OH)*

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Covered expenses include charges made by a **physician** or **behavioral health provider** for services and supplies for the screening, diagnosis, prescription drugs and treatment of Autism Spectrum Disorder. The services and supplies must be prescribed or ordered by a **physician** or a **behavioral health provider**, including a pediatrician or a psychologist trained in Autism Spectrum Disorder, and is as part of a treatment plan.

Coverage also includes outpatient physical rehabilitation services, including physical, speech and occupational therapies, and clinical therapeutic interventions. Clinical therapeutic interventions are defined as therapies supported by empirical evidence that include, but are not limited to, applied behavioral analysis, provided by or under the supervision of a professional that is licensed, certified, or registered by an appropriate agency of Ohio to perform the services in accordance with a treatment plan. Please see your schedule of benefits for any benefit limitations.

Coverage also includes clinical therapeutic interventions such as Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that:

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

Exclusions:

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

- Educational services for behavioral disorders are listed as not covered in the *Medical Plan Exclusions and Limitations* section of the Policy.

Important Note
Covered expenses are contingent on getting **precertification** described in the **precertification** process in this Booklet-Certificate.

Diagnostic and Preoperative Testing *(GR-9N-11-085-01)*

Diagnostic Complex Imaging Expenses

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

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging including positron emission tomography (PET) scans; and
- Any other outpatient diagnostic imaging service where the **recognized charge** exceeds $500.

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

Limitations

This Plan does not cover diagnostic complex imaging expenses under this part of this Plan if such imaging expenses are covered under any other part of this Plan.

Outpatient Diagnostic Lab Work and Radiological Services

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

Important Note
Refer to the *Schedule of Benefits* for details about any **deductible, coinsurance** or benefit maximum that applies to outpatient diagnostic testing, lab and radiological services.

Outpatient Preoperative Testing

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

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**;
- Not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.
- Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.
- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will ***not*** be covered.

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

Limitations

This Plan does not cover diagnostic complex imaging expenses under this part of this Plan if such imaging expenses are covered under any other part of this Plan.

Durable Medical and Surgical Equipment (DME) *(GR-9N S-11-090-01 OH)*

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

The initial purchase of **DME** if:

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

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

Replacement of purchased equipment if:

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

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

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

Important Reminder
Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible**, **coinsurance** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

Clinical Trials *(GR-9N 11-095 04 NG OH)*

Clinical Trial Therapies (Experimental or Investigational)

Covered benefits include "routine patient costs" furnished to a member in connection with participation in an "approved clinical trial" 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:

(A) Federally funded trials

The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(i) The National Institutes of Health.

(ii) The Centers for Disease Control and Prevention.

(iii) The Agency for Health Care Research and Quality.

(iv) The Centers for Medicare & Medicaid Services.

(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(vii) Any of the following:

(I) The Department of Veterans Affairs.

(II) The Department of Defense.

(III) The Department of Energy

if the study or investigation has been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines--

(a) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(b) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In addition, **covered benefits** includes "routine patient care" costs furnished to a member participating in any stage of an "eligible cancer clinical trial" as those terms are defined in the Ohio Revised Code, Section 3923.80 and below, if this plan would cover the routine patient care costs of members not participating in the eligible cancer clinical trial.

Covered benefits also include:

- 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; and
- The experimental intervention itself (except Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

"Eligible cancer clinical trials" means a cancer clinical trial that meets all of the following criteria:

- A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
- The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- The trial does one of the following:
  - Tests how to administer a health care service, item, or drug for the treatment of cancer;
  - Tests responses to a health care service, item, or drug for the treatment of cancer;

- Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
- Studies new uses of a health care service, item, or drug for the treatment of cancer.
- The trial is approved by one of the following entities:
  - The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services;
  - The United States food and drug administration;
  - The United States department of defense;
  - The United States department of veterans' affairs.

In addition, **covered benefits** include charges made for **experimental or investigational** drugs, devices, treatments or procedures under an "approved clinical trial" or an "eligible cancer clinical trial" other than

- "routine patient costs" furnished in connection with an "approved clinical trial," and
- "routine patient care costs" furnished in connection with an "eligible cancer clinical trial,"

provided **all** of the following conditions are met:

- The clinical trial is appropriate for the member's cancer or other life-threatening disease or condition, based on either one of the following:
  - The referring health care professional is a participating health care provider and has concluded that the member's participation in the trial would be appropriate, or
  - The member provides medical and scientific information establishing in Aetna's reasonable judgment that the member's participation in the clinical trial would be appropriate;
- You are treated in accordance with the clinical trial protocol; and
- The sponsors of the clinical trial charges all participants in the clinical trial for the drug, device, treatment or procedure.

You are subject to all of the terms, conditions, provisions, limitations and exclusions of this plan including, but not limited to, **precertification** requirements.

These conditions do not apply to cancer clinical trials.

Exclusions:
Not covered are:
- These clinical trial therapies:
  - 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; and
  - The experimental intervention itself (except Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

Important Notes:
1. Refer to the Schedule of Benefits for details about cost sharing and any benefit maximums that apply to the Clinical Trial benefit. 2. These Clinical Trial benefits are subject to all of the terms; conditions; provisions; limitations; and exclusions of this Plan including, but not limited to, any **precertification** and **referral** requirements.

Pregnancy Related Expenses *(GR-9N 11-100-01-OH)*

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

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

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

Covered expenses also include the charges for post discharge follow-up care for a mother and her newborn ordered and supervised by a **physician**. Services related to maternity follow-up care are covered whether such services are provided in a medical setting or in the home.

If the mother is discharged earlier than the minimum lengths of stay indicated above, all follow-up care received within 72 hours after discharge is covered without regard to medical necessity.

If the mother receives at least the minimum number of hours of inpatient care shown above, follow-up care that is not medically necessary will not be covered.

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

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

Prosthetic Devices *(GR-9N 11-110-01)*

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

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;

- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

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

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

Hearing Aids *(GR-9N-26-005-01)*

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

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

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

Benefits After Termination of Coverage

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

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

Reconstructive or Cosmetic Surgery and Supplies

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

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

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

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

Reconstructive Breast Surgery

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

Important Notice
A benefit maximum may apply to reconstructive or **cosmetic** surgery services. Please refer to the *Schedule of Benefits*.

Short-Term Rehabilitation Therapy Services *(GR-9N 11-120 09 OH)*

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

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

Charges for the following short term rehabilitation expenses are covered:

Cardiac Rehabilitation Benefits

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Certificate**.

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

Pulmonary Rehabilitation Benefits

- Pulmonary rehabilitation benefits are covered as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

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

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet-Certificate**.

- Physical therapy (including spinal manipulation) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries** , provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

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

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in your home, if you are **homebound**.

Important Reminder
Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.

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

- Therapies for the treatment of congenital defects amenable to surgical repair (such as cleft lip/palate);
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or **hospice facility** except as stated above;
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Specialized Care *(GR-9N 11-135-06-OH)*

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

Radiation Therapy Benefits
Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits
Covered expenses include infusion therapy received from an outpatient setting including but not limited to:

- A free-standing outpatient facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

The list of preferred infusion locations can be found by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

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

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

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

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

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

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

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

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

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable **deductible**, **coinsurance** or benefit maximum that apply.

Specialty Care Prescription Drugs

Covered expenses include **specialty care 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 care prescription drug** list as covered under this certificate.

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

Treatment of Infertility *(GR-9N 11-135-06-OH)*

Basic Infertility Expenses

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Comprehensive Infertility Expenses

To be an eligible covered female for benefits you must be covered under this *Booklet-Certificate* as an employee, or be a covered dependent who is the employee's spouse.

Even though not incurred for treatment of an **illness** or **injury**, **covered expenses** will include expenses incurred by an eligible covered female for **infertility** if all of the following tests are met:

- A condition that is a demonstrated cause of **infertility** which has been recognized by a gynecologist, or an infertility specialist, and your **physician** who diagnosed you as **infertile**, and it has been documented in your medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than, 19 miU on day 3 of the menstrual cycle.
- The **infertility** is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this *Booklet-Certificate*.

Comprehensive Infertility Services Benefits *(GR-9N 11-135-01-OH)*

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an infertility specialist upon pre-authorization by **Aetna**, subject to all the exclusions and limitations of this *Booklet-Certificate*:

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

Exclusions and Limitations

Unless otherwise specified above, the following charges will not be payable as **covered expenses** under this *Booklet-Certificate*:

- **Infertility** services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of sterilization surgery;
- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits;
- Injectable **infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
- Any services or supplies provided without pre-authorization from Aetna's infertility case management unit;
- **Infertility** Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not **infertile**;

- Any ART procedure or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); or
- Any charges associated with care required to obtain ART services (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); and any charges associated with obtaining sperm for any ART procedures.

Important Note
Treatment of **Infertility** must be pre-authorized by **Aetna**. Treatment received without pre-authorization will not be covered. You will be responsible for full payment of the services.

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

Transplant Services *(GR-9N-11-160-01-OH)*

Covered expenses include charges incurred during a Transplant Occurrence. Once it has been determined that you or one of your dependents may require an organ transplant, you or your **physician** should call **Aetna** to obtain the necessary precertification. Organ means solid organ; stem cell; bone marrow; and tissue.

Network of Transplant Specialist Facilities

Benefits may vary if an **Institute of Excellence™ (IOE)** facility or non-**IOE** or **out-of-network** provider is used. Through the **IOE** network, you will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

The network level of benefits is paid only for a treatment received at a facility designated by the plan as an **IOE** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from an **IOE** facility will be considered in-network care expenses.

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

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent that it is not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech, and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parent, sibling, or child.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the 4 phases of transplant care described below. Expenses incurred for 1 transplant during these 4 phases of care will be considered 1 Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The 4 phases of 1 Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the Plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous Blood/Bone Marrow transplant followed by Allogenic Blood/Bone Marrow transplant (when not part of a tandem transplant);
- Allogenic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g. a liver transplant with subsequent heart transplant).

Limitations

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

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not a covered person;
- Home infusion therapy after the Transplant Occurrence.

- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing **illness**.
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing **illness**;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

Important Reminders
To ensure coverage, all transplant procedures need to be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for details about **precertification**.

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

Treatment of Mental Disorders and Substance Abuse *(GR-9N-11-172-01)*

Treatment of Mental Disorders *(GR-9N-11-172-01)*

Covered expenses include charges made by a **hospital**, **psychiatric hospital**, **residential treatment facility** or **behavioral health provider** for the treatment of **mental disorders** as follows**:**

- Inpatient **room and board** at the **semi-private room rate,** and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:

  - Office Visits to a **physician** (such as a **psychiatrist)**, psychologist, social worker, or licensed professional counselor, as well as other health professionals. Includes **telemedicine** consultation.

  - Individual, group and family therapies for the treatment of mental disorders.

  - Other outpatient **mental disorder** treatment such as:
    - **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment.
    - Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program 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 because of **illness** or **injury**.
      - Your **physician** orders them.
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home.
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
    - Mental health injectables
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation.

Important Notes:

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

Inpatient treatment and certain outpatient treatments must be **precertified** by **Aetna**. Refer to the *Understanding Your Aetna Medical Expense Insurance* section for details.

Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums and **coinsurance limits** that may apply to your **mental disorder** benefits.

Treatment of Substance Abuse*(GR-9N-11-172-01)*

Covered expenses include charges made by a **hospital**, **psychiatric hospital**, **residential treatment facility** or **behavioral health provider** for the treatment of **substance abuse** as follows:

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

  As used here, "medical complications" include, but are not limited to, 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 (**such as a **psychiatrist)**, psychologist, social worker, or licensed professional counselor, as well as other health care professionals (includes **telemedicine** consultation).

  - Individual, group and family therapies for the treatment of substance abuse.

  - Other outpatient **substance abuse** treatment such as:
    - Outpatient **detoxification**.
    - **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment.
    - Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program under the direction of a **physician**.
    - Ambulatory **detoxification** – Outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications.
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound because of **illness** or **injury**.
      - Your **physician** orders them.
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home.
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
    - Treatment of withdrawal symptoms.
    - Substance use disorder injectables.
    - 23 hour observation.

Important Notes:

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

Please refer to the *Schedule of Benefits* for any **copayments**/**deductibles**, maximums and **coinsurance limits** that may apply to your **substance abuse** benefits.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) *(GR-9N 11-180-01)*

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

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

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

- Treat a fracture, dislocation, or wound.
- Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when ***not*** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

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

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

(a) Natural teeth damaged, lost, or removed; or
(b) Other body tissues of the mouth fractured or cut

due to **injury**.

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

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

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Medical Plan Exclusions *(GR-9N 28-15 16)*

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section.

Important Note:
You have medical and **prescription drug** insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific **prescription drug** coverage. Those additional exclusions are listed separately at the end of this section, if applicable.

Charges made for the following are not covered except to the extent listed under the What The Plan Covers section or by amendment attached to this Booklet-Certificate.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

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

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

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under this Booklet-Certificate, or such drugs or supplies are unavailable or illegal in the United States, or the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

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

Behavioral Health Services:

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 *What the Plan Covers- Preventive Care* section
- Pathological gambling, kleptomania, pyromania
- School and/or education services, including special education, remedial education, wilderness treatment programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mental retardation in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet-Certificate.

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

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

Charges for a service or supply furnished by an **out-of-network provider** in excess of the **recognized charge**.

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

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

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

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

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter the shape or appearance of the body except as specifically described under the *What the Plan Covers* section including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices.

This cosmetic services exclusion does not apply to surgery after an accidental **injury** when performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically described in the *What the Plan Covers* section.

Court ordered services, including those required as a condition of parole or release.

Custodial Care.

Dental Services: Except as specifically described in the *What the Plan Covers* section, any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of **injuries** and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- Services of **dentists**, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth;
- Non-surgical treatments to alter bite or the alignment or operation of the jaw, except as specifically described in the *What the Plan Covers* section, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

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

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

Drugs, medications and supplies (except as specifically described in the *What the Plan Covers* section) including:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any **prescription drug** purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to travel or work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-**covered expenses**;
- Performance enhancing steroids;
- Implantable drugs and associated devices;
- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drug**s;
- Self-injectable **prescription drug**s and medications;
- Any **prescription drug**s, injectables, or medications or supplies provided by the Policyholder or through a third party vendor contract with the Policyholder;
- Any expenses for prescription drugs, and supplies covered under an **Aetna** managed prescription plan will not be covered under this medical expense plan; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Early intensive behavioral interventions:

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

Educational services:

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

Examinations, except as described in the *What the Plan Covers* section and required under the federal preventive care services:

- Any health examinations required:
  - By a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - By any law of a government;
  - For securing insurance, school admissions or professional or other licenses;
  - To travel;
  - To attend a school, camp, or sporting event or participate in a sport or other recreational activity.

- Any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;

- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

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

Foot care: Except as specifically covered in the *What the Plan Covers* section -- any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:

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

Growth/Height: Any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones.

Hearing: Except as specifically covered in the *What the Plan Covers* section

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility;
- Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

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

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

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries, except for **emergency medical conditions**.

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

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;

- Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, 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;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- Any charges associated with care required to obtain ART Services (e.g., office, **hospital**, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care.

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

Miscellaneous charges for services or supplies:

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

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

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

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including:

- Telephone, television, internet, barber or beauty service or other guest services;
- Housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and
- Travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

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

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, 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;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care.

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

Miscellaneous charges for services or supplies:

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

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

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

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including:

- Telephone, television, internet, barber or beauty service or other guest services;
- Housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and
- Travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

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

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, 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;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care.

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

Miscellaneous charges for services or supplies including:

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

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

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

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including:

- Telephone, television, internet, barber or beauty service or other guest services;
- Housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and
- Travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services. Skilled nursing care is covered as specifically described in the *What the Plan Covers* section in accordance with a home health treatment plan approved by **Aetna**.

Prosthetics or prosthetic devices unless specifically covered under *What the Plan Covers* Section.

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

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

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

Sexual dysfunction/enhancement: except as specifically described in the *What the Plan Covers* section, any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

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

Tobacco Use: except as specifically described in the *What the Plan Covers* section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet-Certificate.

Services that are not covered under this Booklet-Certificate.

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

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

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

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

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

Telemedicine:

- Services given by **providers** that are not contracted with **Aetna** as **telemedicine providers**
- Services given when you are not present at the same time as the **provider**
- Services including:
  - Telephone calls for behavioral health services
  - **Telemedicine** kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered except as specifically described in the *What the Plan Covers* section. Examples of non-covered diagnoses include Pervasive Developmental Disorders, Down syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Therapies and tests: Any of the following treatments or procedures:

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

Transplant Related Services- except as specifically described in the *What the Plan Covers* section, the transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**.

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in *What the Plan Covers* section.

Vision-related services and supplies, except as described in the *What the Plan Covers* section, not covered under this section:

- Anti-reflective coatings;
- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Tinting of eyeglass lenses;
- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams to diagnose or treat an **illness** or **injury** (This is covered under your medical benefits.);
- 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;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.

Weight: except as specifically described in the *What the Plan Covers* section, including preventive services for obesity screening and weight management interventions, a treatment or drug intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions, including but not limited to:

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

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

Your Pharmacy Benefit *(GR-9N-12-005-06 OH)*

How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your **prescription drug** plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access **network pharmacies** and procedures you need to follow;
- What **prescription drug** expenses are covered and what limits may apply;
- What **prescription drug** expenses are not covered by the plan;
- How you share the cost of your covered **prescription drug** expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

Important Notes:

- Unless otherwise indicated, "you" refers to you and your covered dependents. You can refer to the *Eligibility* section for a complete definition of "you".
- The plan pays benefits only for **prescription drug** expenses described in this *Booklet-Certificate* as **covered expenses** that are **medically necessary**.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive **prescription drugs** that are not or might not be covered benefits under this **prescription drug** plan.
- Store this *Booklet-Certificate* in a safe place for future reference.

(GR-9N 12-005 01 OH)

Notice

The plan does not cover all **prescription drugs**, medications and supplies. Refer to the *Prescription Drug Limitations* section and the *Exclusions* section of this *Booklet-Certificate*.

- **Covered expenses** are subject to cost sharing requirements as described in the *Cost Sharing* section and the *Schedule of Benefits*.
- **Injectable drugs** and **specialty care drugs** will only be covered when obtained through a **specialty pharmacy network** pharmacy.

Getting Started: Common Terms

You will find the terms below used throughout this Booklet-Certificate. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary*.

Brand-Named Prescription Drug is a **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by **Aetna**.

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

Network pharmacy is a description of a **retail, mail order or specialty pharmacy** that has entered into a contractual agreement with **Aetna, an affiliate, or a third party vendor,** for the provision of **covered services** to you and your covered dependents. The appropriate **pharmacy** type may also be substituted for the word **pharmacy**. (E.g. **network retail pharmacy, network mail order pharmacy or specialty pharmacy network**).

Non-Preferred Drug (Non-Formulary) is a **brand-named prescription drug** or **generic prescription drug** that does not appear on the **preferred drug guide**.

Out-of-network pharmacy is a description of a **pharmacy** that has not contracted with **Aetna, an affiliate, or a third party vendor,** and does not participate in the pharmacy network.

Preferred Drug (Formulary) is a **brand-named prescription drug** or **generic prescription drug** that appears on the **preferred drug guide**.

Preferred Drug Guide is a listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand-named prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and changes by **Aetna**. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.aetna.com/formulary.

Prescription Drug is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

Provider is any recognized health care professional, pharmacy or facility providing services with the scope of their license.

Self-injectable Drug(s). Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of **Self-injectable Drugs**, designated by **Aetna** as eligible for **coverage** shall be available upon request or may be accessed at the **Aetna** website, at www.aetna.com. The list is subject to change by **Aetna** or an affiliate.

Accessing Pharmacies and Benefits *(GR-9N 12-015 01 OH)*

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. Aetna has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network** and **out-of-network benefits**. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty pharmacies.

You also have the choice to access Ohio licensed **pharmacies** outside the **network** for **covered expenses**.

Accessing Network Pharmacies and Benefits

You may select a **network pharmacy** from Aetna's on-line provider directory which can be found at www.aetna.com. You can search **Aetna**'s online directory, DocFind, for names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area, call Member Services at the number on your ID card.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for **network pharmacy benefits**. The **network pharmacy** will calculate your claim online. You will pay any **deductible**, **copaymen**t or **coinsurance** directly to the **network pharmacy**. You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

Emergency Prescriptions

When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain **network pharmacy** benefits by filling your **prescription** at any **network pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan's cost sharing amount.

If you access an **out-of-network pharmacy** you will pay the full cost of the **prescription** and will need to file a claim for reimbursement. You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less your plan's cost sharing for **network pharmacy** benefits.

Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the provider contract.

Cost Sharing for Network Benefits

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

- You will need to satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The **copayment** is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.
- After you satisfy any applicable **deductible** and pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** amount is determined by applying the applicable **coinsurance** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

When You Use an Out-of-Network Pharmacy *(GR-9N-12-020-01 OH) (GR-9N 13-005 01 OH)*

You can directly access an **out-of-network pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-network **pharmacy**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

Cost Sharing for Out-of-Network Benefits *(GR-9N-12-020-01 OH)*

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

- You will need to satisfy any applicable calendar year **deductibles** before the plan will begin to pay benefits.

- After you satisfy any applicable year **deductible(s)**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** share is based on the **recognized charge**. If the **out-of-network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

Pharmacy Benefit *(GR-9N 13-006 04)*

What the Plan Covers

The plan covers charges for **medically necessary** outpatient **prescription drugs** for the treatment of an **illness** or **injury**, subject to the *Prescription Drug Limitations* section below and the *Exclusions* section of the *Booklet-Certificate*. **Prescriptions** must be written by a **prescriber** licensed to prescribe federal legend **prescription drugs**.

Your prescription drug benefit coverage is based on **Aetna's preferred drug guide**. Your out-of-pocket expenses may be higher if your **physician** prescribes a covered **prescription drug** not appearing on the **preferred drug guide**.

Preferred generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. You may minimize your out-of-pocket expenses by selecting a **generic prescription drug** when available.

Coverage of **prescription drugs** may, in **Aetna**'s sole discretion, be subject to **precertification**, or other **Aetna** requirements or limitations. **Prescription drugs** covered by this plan are subject to drug utilization review by **Aetna** and/or your **provider** and/or **your network pharmacy**.

The plan does not cover charges for **prescription drugs** listed on **formulary exclusions list**. Drugs on the **formulary exclusions list** are excluded from coverage unless a medical exception for coverage is obtained. If it is **medically necessary** for you to use a **prescription drug** on the **formulary exclusions list**, the **prescriber** who prescribed the drug must request coverage as a medical exception. Refer to the Medical Exceptions description under precertification for information on how your **prescriber** can obtain a medical exception for your prescription if necessary.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

Retail Pharmacy Benefits *(GR-9N 13-008 03 OH)*

Outpatient **prescription drugs** are covered when dispensed by a retail network **pharmacy** or a retail **out-of-network pharmacy**. When you go to a retail **pharmacy**, each **prescription** is limited to a maximum 30 day supply when filled at a retail **pharmacy**. **Prescriptions** for more than a 30 day supply are not eligible for coverage when dispensed by a retail **pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by 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 when dispensed by a **network mail order pharmacy**.

Network Benefits for Specialty Care Drugs *(GR-9N 13-009-01)*

Self-injectable drugs are covered at the network level of benefits only when dispensed through a **network retail pharmacy** or **Aetna's specialty pharmacy network**. Refer to the **preferred drug guide** for a list of **self-injectable drugs**. You may refer to **Aetna's** website, www.aetna.com to review the list anytime. The list may be updated from time to time.

The initial prescription for a **self-injectable drug** must be filled at a **network retail pharmacy** or at **Aetna's specialty pharmacy network**.

Other Covered Expenses *(GR-9N 13-005 01 OH)*

The following **prescription drugs**, medications and supplies are also **covered expenses** under this Coverage.

Off-Label Use *(GR-9N 13-005 01 OH)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia adopted by the United States Department of Health and Human Services, or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **Aetna's** sole discretion, be subject to **precertification**, or other **Aetna** requirements or limitations.

Diabetic Supplies *(GR-9N 13-005 01 OH)*

The following diabetic supplies upon prescription by a **physician**:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Contraceptives *(GR-9N 11-006 04 NG OH)*

Covered expenses include charges made by a **network pharmacy** for the following contraceptive methods when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing:

- Female oral and injectable contraceptives that are **generic prescription drugs**.
- Female contraceptive devices.
- FDA-approved female:
  - Generic, emergency contraceptives; and
  - Generic over-the-counter (OTC) emergency contraceptives obtained without a **prescription**.
- FDA-approved female generic over-the-counter (OTC) contraceptives;

Important Note:
This Plan does not cover all contraceptives. For a current listing, contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Contraceptives can be paid either under your medical plan or **pharmacy** plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive p**rescription drugs** and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit.

Refer to the Copay and Deductible Waiver section of your Schedule of Benefits for cost-sharing information.

Important Notes:

1. The Copay and Deductible Waiver does <u>not</u> apply to contraceptive methods that are:
   - **Brand-name prescription drugs**;
   - FDA-approved female:
     - brand-name emergency contraceptives; and
     - brand-name over-the-counter (OTC) emergency contraceptives; and
   - FDA-approved female brand-name over-the-counter (OTC) contraceptives.

   However, the Copay and Deductible Waiver does apply when:

- such contraceptive methods are not available within the same **therapeutic drug class**; or
- a generic equivalent, biosimilar or generic alternative, within the same **therapeutic drug class** is not available; and
- you are granted a medical exception. Refer to Medical Exceptions described below; above in the Precertification section for information on how you or your **prescriber** can obtain a medical exception.

2. A generic equivalent contains the identical amounts of the same active ingredients as the **brand-name prescription drug** or device. A generic alternative is used for the same purpose, but can have different ingredients or different amounts of ingredients.

Oral and Self-Injectable Infertility Drugs

The following **prescription drugs** used for the purpose of treating infertility including, but not limited to:

- Urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

Preventive Care Drugs and Supplements *(GR-9N 13-022 01 NG OH)*

Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a **network pharmacy**. They are covered when they are:

- prescribed by a **physician**;
- obtained at a **pharmacy;** and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this Plan include, but may not be limited to:

- Aspirin: Benefits are available to adults.
- Folic Acid Supplements: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- Iron Supplements: Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- Oral Fluoride Supplements: Benefits are available to children whose primary water source is deficient in fluoride.
- Vitamin D Supplements: Benefits are available to adults to promote calcium absorption and bone growth in their bodies.
- Risk-Reducing Breast Cancer Prescription Drugs**. Covered medical expenses** include charges incurred for **generic prescription drugs** prescribed by a **physician** for a woman who is at increased risk for breast cancer and is at low risk for adverse medication side effects.

Coverage for preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

The federal website is included here for your reference:

http://www.healthcare.gov/center/regulations/prevention.html

The covered preventive drugs are governed by the USPSTF and HRSA – the link below includes those preventive care drugs and supplements listed above:

http://www.uspreventiveservicestaskforce.org/BrowseRec

Important Note:
For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com and Aetna Navigator, or calling the number on the back of your ID card.

Tobacco cessation prescription and over-the-counter drugs *(GR-9N 13-022 01 NG OH)*

Covered expenses 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.

Refer to the Schedule of Benefits for the cost-sharing and supply limits that apply to these benefits.

Precertification *(GR-9N-S-13-010-01 OH)*

Precertification is required for certain outpatient **prescription drugs**. **Prescribers** must contact **Aetna** to request and obtain coverage for such **prescription drugs**. The list of drugs requiring **precertification** is subject to periodic review and change by **Aetna**. For the most up to date information, call the toll-free number on your member ID card or log on to your Aetna Navigator secure member website at www.aetna.com.

Benefits will be reduced if **Aetna** does not **precertify** your **prescription drug**. So ask your **prescriber** or pharmacist if your **prescription drug** needs to be **precertified.**

How to Obtain Precertification *(GR-9N-S-13-010-01 OH)*

If an outpatient **prescription drug** requires **precertification** and you use a **network pharmacy** the **prescriber** is required to obtain **precertification** for you.

When you use an **out-of-network pharmacy**, you can begin the **precertification** process by having the **prescriber** call **Aetna** at the number on your ID card.

Aetna will let your **prescriber** know if the **prescription drug** is **precertified.**

If the **prescription drug** is denied **precertification**, **Aetna** will notify you how the decision can be appealed.

Medical Exceptions:

Your **prescriber** may seek a medical exception to obtain coverage for drugs listed on the **formulary exclusions list** or for which coverage is denied through **Precertification**. You or your **prescriber** must submit such exception requests to Aetna. Coverage granted as a result of a medical exception shall be based on an individual, case by case **medical necessity** determination and coverage will not apply or extend to other covered persons.

Pharmacy Benefit Limitations *(GR-9N 13-015 08 OH)*

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.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the *Complaint and Appeals* section(s) of this Booklet-Certificate.

Aetna reserves the right to include only one manufacturer's product on the **preferred drug list** when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

Aetna reserves the right to include only one dosage or form of a drug on the **preferred drug list** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug list** will be covered at the applicable **copayment** or **coinsurance**.

The number of **copayments/deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any **prescription drug** dispensed by a **mail order pharmacy** for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

Some **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your **prescription drug** is used correctly and safely. **Aetna** relies on medical guidelines, FDA-approved recommendations from drug makers and other criteria developed by **Aetna** to set these quantity limits. The quantity limit may restrict either the amount dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to a single commercially prepackaged item excluding insulin, diabetic supplies, test strips dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to 100 units excluding insulin dispensed per **prescription** order or refill.

Any **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**.

Specialty care prescription drugs may have limited access or distribution and are subject to supply limits.

Plan approved blood glucose meters, asthma holding chambers and peak flow meters are **eligible health services**, but are limited to one (1) **prescription** order per **calendar year**.

Pharmacy Benefit Exclusions *(GR-9N 28-020 14 OH)*

Not every health care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are ***not*** covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this *Booklet-Certificate*. In addition, some services are specifically limited or excluded. This section describes expenses that are ***not*** covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

Abortion drugs.

Administration or injection of any drug.

Any charges in excess of the benefit, day, or supply limits stated in this *Booklet-Certificate*.

Allergy sera and extracts administered via injection.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this *Booklet-Certificate*. This also includes **prescription drugs** or supplies if:

- Such **prescription drugs** or supplies are unavailable or illegal in the United States, or
- The purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Any drugs or medications, services and supplies that are not **medically necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**. This does not apply to mandated preventive care drugs.

Biological sera, blood, blood plasma, blood derivatives or substitutes or any other blood products.

Contraceptive **prescription drugs**, devices, services and supplies (except as specifically described in the *Preventive Care Benefits* and *Additional Covered Expenses* section) including:

- Services associated with the prescribing, monitoring and/or administration of **prescription drug** contraceptives and devices.
- Female contraceptives that are **brand-name prescription drugs** and biosimilar **prescription drugs**; and
- FDA-approved female brand-name and biosimilar emergency contraceptives.

Contraception – Male condoms.

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 specifically covered in the *What the Plan Covers* section.

Dietary supplements including medical foods.

Drugs administered or entirely consumed at the time and place it is prescribed or dispensed.

Drugs for which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration).

Drugs not approved by the FDA or not proven safe and effective.

Drugs recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Aetna's** Pharmacy and Therapeutic Committee.

Drugs 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 covered in the *What the Pharmacy Plan Covers* section.

Drugs provided under your medical plan while an inpatient of a healthcare facility.

Drugs that include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF).

Drugs used for methadone maintenance medications used for drug detoxification.

Drugs 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; and
- other medications.

Drugs used for the treatment of obesity.

Drugs that are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile dysfunction, enhance sensitivity, or alter the shape or appearance of a sex organ.

All 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.

Drugs or medications that include the same active ingredient or a modified version of an active ingredient as a covered prescription drug (unless a medical exception is approved).

Drug or medication that is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** including biosimilars.

Drug or medication that is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product.

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

Durable medical equipment, monitors and other equipment.

Experimental or investigational drugs or devices, except as described in the *What the Plan Covers* section.

This exclusion will ***not*** apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the **illness**.

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

Genetics: Any treatment, device, drug, 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.

Immunization or immunological agents.

Immunizations related to travel or work.

Implantable drugs and associated devices.

Self-injectables:

- Any charges for the administration or injection of **prescription drugs** or self-injectable insulin and other injectable drugs covered by **Aetna e**xcept as described in the *What the Plan Covers* section;
- Needles and syringes, except those used for self-administration of an self-injectable drug;
- For 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 self-injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

Medications or preparations used for cosmetic purposes.

Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

Prescription drugs, medications, self-injectables or supplies provided through a third party vendor contract with the policyholder.

Prescription drugs listed in the **formulary exclusions** list in the **preferred drug guide** unless a medical exception has been obtained.

Prescription drugs 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.

Prescription drugs that include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is no clinically superior to that drug as determined by the plan.

Prescription drugs that are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition.

Prescription drugs that are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered 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.

Prescription drugs 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.

Prescription orders filled prior to the effective date or after the termination date of coverage under this Booklet-Certificate.

Refills in excess of the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or evidence as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescription**s.

Drugs, services and supplies provided in connection with treatment of an **occupational injury** or **occupational illness**.

Tobacco use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum that is not recommended by the United States Preventive Services Task Force (USPSTF).

Strength and performance: Drugs or preparations, devices or supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

When Coverage Ends *(GR-9N-30-015-04)*

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

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, **Aetna** may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not actively at work due to **illness or injury**, your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

Your Proof of Prior Medical Coverage *(GR-9N-30-010-01 OH)*

Under the Health Insurance Portability and Accountability Act of 1996, you are entitled to receive a certificate of **creditable coverage** when your employment ends. This certificate proves that you had **creditable coverage** when you were employed. Ask your employer about the certificate of **creditable coverage**.

When Coverage Ends for Dependents *(GR-9N-30-015-02)*

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

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

Continuation of Coverage *(GR-9N-31-015-05)*

Continuing Health Care Benefits *(GR-9N-31-015-06)*

Continuing Coverage for Dependent Students on Medical Leave of Absence *(GR-9N 31-015 01 OH)*

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

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

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

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

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

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

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

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

Handicapped Dependent Children *(GR-9N 31-015 01 OH)*

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child.

Your child is fully handicapped if:

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

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 90 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.

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

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

Continuing Coverage for Reservist Called to Active Duty

Any eligible person may continue health care benefits under the group policy for a period of 18 months after the date on which a reservist's coverage under the group policy would otherwise end because he or she was called to active duty.

The term "eligible person" means you, if you are a reservist called to active duty, and your covered spouse and dependent children. The term "reservist" means a member of a reserve component of the armed forces of the United States including the Ohio National Guard.

If you are a reservist and are called to active duty, your employer shall notify each eligible person of this continuation right and explain how to enroll for this continued coverage and the amount of the required contribution. The eligible person must elect continuation and pay the required contribution to the employer by the earlier of:

- 31 days after the date coverage would otherwise terminate;
- 31 days after the date your employer notifies the eligible person of the right to continuation.

Coverage may be extended up to a 36 month period if any one of the following occurs during the 18 month continuation:

- The death of the reservist;
- The divorce or separation of a reservist from the reservist's spouse;
- The child no longer qualifies as a dependent child under the terms of the group policy.

The 36 month period is deemed to begin on the date of any occurrence above.

Coverage under this continuation as to an eligible person will end on the earlier to occur of the following:

- The 18 month, or if applicable, the extended 36 month period, expires.
- Required contributions are not made when due.
- The eligible person enrolls in another group health policy that does not contain a preexisting conditions limitation or exclusion.
- The group policy is terminated, unless replaced by similar coverage.

Extension of Benefits *(GR-9N 31-020 01)*

Coverage for Health Benefits

If your health benefits end while you are totally disabled, your health expenses will be extended as described below, but, with respect to medical benefits, only as to expenses incurred in connection with the **injury** or **illness** that caused the total disability. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

"Totally disabled" means that because of an **injury** or **illness**:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage *(GR-9N 31-020 01)*

(GR-9N 31-020 01)
Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

Prescription Drug Benefits: Coverage will be available while you are totally disabled for up to 12 months.

When Extended Health Coverage Ends
Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

Important Note
If the Extension of Benefits provision outlined in this section applies to you or your covered dependents, see the *Converting to an Individual Health Insurance Policy* section for important information.

COBRA Continuation of Coverage *(GR-9N 31-025-06 OH)*

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a "qualifying event" that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA
When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer's notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

Who Qualifies for COBRA
You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
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 dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events.

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Premium Payments for Continuation Coverage

Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 % of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 % of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

Important Note

For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

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

(GR-9N 33-005-01-OH)

When Coordination of Benefits Applies

General

A. This coordination of benefits ("COB") provision applies to **This Plan** when an employee or the employee's covered dependent has health care coverage under more than one plan. "**Plan**" and "**This Plan**" are defined below.
B. If this COB provision applies, you should look first at the order of benefit determination rules. Those rules determine whether the benefits of **This Plan** are determined before or after those of another plan. The benefits of **This Plan**:
   - Shall not be reduced when, under the order of benefit determination rules, **This Plan** determines its benefits before another plan; but
   - May be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

Getting Started - Important Terms

A. "**Plan**" means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
   - Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other then school accident-type coverage.
   - Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
   - "**Plan**" does not include school accident-type coverage, individual contracts of coverage, or some supplemental sickness and accident policies.
   - Each contract or other arrangement for coverage under (1) or (2) is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate plan.
B. "**This Plan**" is the part of this group contract that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" the order of benefit determination rules state whether **This Plan** is a Primary Plan or Secondary Plan as to another plan covering the person. When **This Plan** is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When **This Plan** is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, **This Plan** may be a Primary Plan as to one or more other plans and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered by this plan. However, **This Plan** is not required to pay for an item, service, or benefit which is not a part of this **Plan's** contract. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

Which Plan Pays First *(GR-9N 33-010-01-OH)*

A. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan whose benefits are determined after those of the other plan, unless:
   1) The other plan has rules coordinating its benefits with those of This Plan; and
   2) Both those rules and this plan's rules, in subsection below, require that this plan's benefits be determined before those of the other plan.

B. This Plan determines its order of benefits using the first of the following rules which applies:
   1) The benefits of the plan which covers the person as an employee, member, insured, or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is;
      - Secondary to the plan covering the person as a dependent and
      - Primary to the plan covering the person as other than a dependent (e.g. a retired employee).
   2) Benefits for a dependent child whose parents are not separated or divorced shall be determined as follows:
      - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
      - If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which has covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (A) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

   3) Benefits for a dependent child whose parents are divorced or separated shall be determined as follows. To the extent the plan has been notified by receiving a copy of the court decree:
      - If the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, the benefits of the plan of that parent are determined first. The plan of the other parent shall be the Secondary Plan.
      - If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall be subject to the order of benefit determination contained in subdivision (B)(2) of this section.

If neither subdivision (A) nor (B) applies, the order of benefits shall be determined in the following order:

1) The plan of the parent with custody of the child;
2) The plan of the spouse of the parent with the custody of the child;
3) The plan of the parent not having custody of the child; and
4) The plan of the spouse of the parent not having custody of the child.
5) The benefits of a plan which covers a person as an employee who is neither laid off not retired (or as that employee's dependent) are determined before the benefits of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph shall be ignored.

6) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (i.e., COBRA) or state law also is covered under another plan, the benefits of the plan covering the person as employee, member or subscriber (or that person's dependent) shall be determined before the benefits under the continuation coverage. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph shall be ignored.
7) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

How Coordination of Benefits Works

A. This section applies when, in accordance with the "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in (B) below.
B. Reduction in This Plan's benefits. The benefits of This Plan will be reduced to the extent that the sum of:
   - The benefits that would be payable for the allowable expense under This 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 claim is made, exceeds those allowable expenses.

If the allowable expense under This Plan is lower than the primary plan's, Aetna will use the primary plan's allowable expense. That may be lower than the actual bill.

Right To Receive And Release Needed Information *(GR-9N 33-015-01-OH)*

Certain facts are needed to apply these COB rules. **Aetna** has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. **Aetna** need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give **Aetna** any facts it needs to pay the claim.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Another plan; or
- The provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686- 1526.

When You Have Medicare Coverage

(GR-9N-33-020-01)

This section explains how the benefits under **This Plan** interact with benefits available under **Medicare**.

Medicare, when used in this Booklet-Certificate, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It 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** if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under it because you:
  1. Refused it;
  2. Dropped it; or
  3. Failed to make a proper request for it.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the primary payor, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the secondary payor, and pays benefits after **Medicare**.

Which Plan Pays First

The plan is the primary payor when your coverage for the **plan**'s benefits is based on current employment with your employer. The **plan** will act as the primary payor for the **Medicare** beneficiary who is eligible for **Medicare**:

- Solely due to age if the **plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for **Medicare** benefits. This provision does not apply if, at the start of eligibility, you were already eligible for **Medicare** benefits, and the **plan**'s benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the **plan** meets the definition of a large group health plan as outlined in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

The **plan** pays benefits first when it is the primary payor. You may then submit your claim to **Medicare** for consideration.

When Medicare is Primary

Your health care expense must be considered for payment by **Medicare** first. You may then submit the expense to **Aetna** for consideration.

Aetna will calculate the benefits the **plan** would pay in the absence of **Medicare**:

The amount will be reduced so that when combined with the amount paid by **Medicare**, the total benefits paid or provided by all plans for the claim do not exceed 100 % of the total **allowable expense**.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **plan** in the order received by **Aetna**. **Aetna** will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information *(GR-9N-33-025-01)*

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **This Plan** and other **plans**. **Aetna** has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

General Provisions *(GR-9N-32-005-02)*

Type of Coverage

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

Physical Examinations

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

Legal Action

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

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of the plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna**'s Notice of Information Practices by calling **Aetna**'s toll-free Member Service telephone.

Additional Provisions

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *group policy*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

Assignments *(GR-9N-32-005-02-OH)*

Coverage may be assigned only with the written consent of **Aetna**. To the extent allowed by law, **Aetna** will not accept an assignment to an **out-of-network provider**, including but not limited to, an assignment of:

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

Misstatements *(GR-9N-32-005-03)*

If any fact as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by you, an eligible employee or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Rescission of Coverage *(GR-9N-32-005-03)*

Aetna may rescind your coverage if you, or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage.

As to medical and prescription drug coverage only, you have the right to an internal **Appeal** with **Aetna** and/or the right to a third party review conducted by an independent **External Review** Organization if your coverage under this Booklet-Certificate is rescinded retroactive to its Effective Date.

Subrogation and Right of Reimbursement *(GR-9N-32-010-01-OH)*

As used herein, the term "**Third Party**", means any party that is, or may be, or is claimed to be responsible for **illness** or **injuries** to you. Such **illness** or **injuries** are referred to as "**Third Party Injuries**." "**Third Party**" includes any party responsible for payment of expenses associated with the care of treatment of **Third Party Injuries**.

If this plan pays benefits under this Booklet-Certificate to you for expenses incurred due to **Third Party Injuries**, then **Aetna** retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the **Third Party Injuries**. **Aetna**'s rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a **Third Party** or any insurance company on behalf of the **Third Party**;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for **injuries** resulting from an accident or alleged negligence with the exception of claims by you pursuant to the property damage provisions of any insurance policy.

By accepting benefits under this plan, you specifically acknowledge **Aetna**'s right of subrogation. When this plan pays health care benefits for expenses incurred due to **Third Party Injuries**, **Aetna** shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this plan. **Aetna** may proceed against any party with or without your consent.

By accepting benefits under this plan, you also specifically acknowledge **Aetna**'s right of reimbursement. This right of reimbursement attaches when this plan has paid benefits due to **Third Party Injuries** and you or your representative has recovered any amounts from a **Third Party**. By providing any benefit under this Booklet-Certificate, **Aetna** is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. **Aetna**'s right of reimbursement is cumulative with and not exclusive of **Aetna**'s subrogation right and **Aetna** may choose to exercise either or both rights of recovery.

By accepting benefits under this plan, you or your representatives further agree to:

- Notify **Aetna** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to **Third Party Injuries** sustained by you;
- Cooperate with **Aetna** and do whatever is necessary to secure **Aetna**'s rights of subrogation and reimbursement under this Booklet-Certificate;
- Give **Aetna** a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with **Third Party Injuries** provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due **Aetna** as reimbursement for the full cost of all benefits associated with **Third Party Injuries** paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **Aetna** in writing; and
- Do nothing to prejudice **Aetna**'s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of **Third Party Injuries**.

Aetna may recover full cost of all benefits paid by this plan under this Booklet-Certificate without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **Aetna**'s recovery, and **Aetna** is not required to pay or contribute to paying court costs or attorney's

fees for the attorney hired by you to pursue your claim or lawsuit against any **Third Party** without the prior express written consent of **Aetna**. In the event you or you representative fail to cooperate with **Aetna**, you shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by **Aetna** in obtaining repayment.

Workers' Compensation

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

The Recovery Rights will be applied even though:

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

You hereby agree that, in consideration for the coverage provided by this policy, you will notify **Aetna** of any Workers' Compensation claim you make, and that you agree to reimburse **Aetna** as described above.

If benefits are paid under this policy and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna** has a right to recover from you or your covered dependent an amount equal to the amount **Aetna** paid.

Recovery of Overpayments *(GR-9N-32-015-01-OH)*

Health Coverage

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

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

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

Reporting of Claims

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

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

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

Payment of Benefits *(GR-9N-32-025-02)*

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

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

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

Any unpaid balance will be paid within 30 days of receipt by **Aetna** of the due written proof.

Aetna may pay up to $1,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

When a **PCP** provides care for you or a covered dependent, or care is provided by **a network provider** (**network services or supplies**), the **network provider** will take care of filing claims. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

Records of Expenses *(GR-9N-32-030-02)*

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

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

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Effect of Benefits Under Other Plans *(GR-9N 32-035-01)*

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

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care), if any, on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

Any extensions of benefits under this plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan providing medical coverage. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- The end of a 90 day period; and
- The date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Prior Coverage - Transferred Business *(GR-9N-32-040-02)*

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

coverage under any Major or Comprehensive Medical Expense Coverage section of this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided under the section, *Continuing Coverage for Dependent Students on Medical Leave of Absence*.

Discount Programs *(GR-9N-32-045-01-OH)*

Discount Arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third party service **providers**". These third party service

providers may pay us so that they can offer you their services.

The third party service **providers** are independent contractors. The third party service provider is responsible for the goods or services they deliver.

We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service **providers** for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and Other Incentives *(GR-9N-32-045-01-OH)*

Aetna may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and continue participation as an **Aetna** member through incentives. You and your **physician** can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, **Aetna** may provide incentives based on your participation and your results. Incentives may include but are not limited to:

- Modifications to **copayment**, **deductible**, or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards, or
- Any combination of the above.

Appeals Procedure *(GR-9N 32-050 02 OH)*

Definitions

Adverse Benefit Determination (Decision) means:

A decision by **Aetna**:

- To deny, reduce, terminate or fail to provide or make payment in whole or in part, for a service, supply or benefit. Such **adverse benefit determination** may be include all of the following:
  - Your eligibility for coverage.
  - A determination that the health care services does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments.
  - A determination of your eligibility for individual health insurance coverage, including coverage offered through a non-employer group, to participate in a plan or health insurance coverage.
  - The results of any Utilization Review activities.
  - A determination that a health care service is not a covered benefit.
  - The imposition of an exclusion, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to you, including coverage offered through a non-employer group.
- As to medical and prescription drug claims only, an **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

Appeal: An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

Authorized Representative: An individual who represents you in an internal appeal or external review process of an **adverse benefit determination** who is any of the following:

- A person to whom you have given express, written consent to represent you in an internal appeals process or external review process of an **adverse benefit determination**;
- A person authorized by law to provide substituted consent for you;
- A family member or a treating health care professional, but only when you are unable to provide consent.

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

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

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

Covered Benefits or **Benefits:** Those health care services to which a covered person is entitled under the terms of a health benefit plan.

Covered Person: Policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's **authorized representative** with regard to an internal appeal or external review.

Emergency Services:

- A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;
- Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the **appeals** process.

Health Benefit Plan: A policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Health Care Services: Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Plan Issuer: An entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the **superintendent** of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health Plan Issuer" includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the **superintendent**.

Independent Review Organization: An entity that is accredited to conduct independent external reviews of **adverse benefit determinations**.

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

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

Rescission or **to rescind:** A cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Stabilize: The provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
    - Serious impairment to bodily functions;
    - Serious dysfunction of any bodily organ or part.
- In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Superintendent: The Superintendent of Insurance.

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

- Seriously jeopardize your life or health;
- Affect you or others safety due to the patient's psychological state;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and appeals only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and **prescription drug** claims only, if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a **concurrent care claim**, to your **provider**.

Urgent Care Claims

Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than 48 hours after the claim is made.

If more information is needed to make an urgent claim decision, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the **physician** to provide **Aetna** with the information.

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

The **precertification** request may be submitted through a secure electronic transmission. **Aetna** will respond in the same manner as indicated above. A facsimile is not considered a secure electronic transmission. **Aetna** will provide an electronic receipt acknowledging the request and receipt of any additional information.

Pre-Service Claims

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

If the **precertification** request is submitted through a secure electronic transmission, **Aetna** will respond to the request within 10 calendar days with an approval or denial. **Aetna** will provide an electronic receipt acknowledging the request and receipt of any additional information.

- If the **precertification** is denied, **Aetna** will let your **provider** know the specific reason for the denial.
- If the request is incomplete **Aetna** will let your **provider** know what specific information is required to process the request.

A facsimile is not considered a secure electronic transmission.

Post-Service Claims

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

Concurrent Care Claim Extension

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

Concurrent Care Claim Reduction or Termination

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

If you file an **appeal**, coverage under the plan will continue for the previously approved ongoing course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints

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

Notice of an Adverse Determination

When **Aetna** notifies you of an **adverse benefit determination** in writing, you will also be notified of your right to an **external review**. As part of the written notice, the Plan will include the following:

- Sufficient information to identify the claim or health care service involved, including the health care provider, and the date of service and claim amount, if applicable;
- A description of the reason or reasons for the **adverse benefit determination**, including the denial code, such as the claim adjustment reason code and the remittance advice remark code, and each code's corresponding meaning;
- A description of the available internal **appeals** and **external review** processes, including information regarding how to initiate an **appeal** and an **external review**; and
- Disclosure of the availability of assistance from the **superintendent** with the internal appeals and external review processes, including the web site, telephone number, and mailing address of the **superintendent's** Office of Consumer Services.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level of **appeal**. A **final adverse benefit determination** notice will also provide an option to request an **External Review** if the services are eligible for external review.

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an **adverse benefit determination** to request your **appeal**. Your **appeal** may be submitted orally or be submitted in writing and must include:

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

Send your written **appeal** to Member Services at the address shown on your ID Card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna.**

Appeal

A review of an **appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 48 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

If the appeal request is submitted through a secure electronic transmission, **Aetna** will respond to the request within 10 calendar days with an approval or denial. A facsimile is not considered a secure electronic transmission.

If the appeal does not resolve the matter, you or your authorized representative may request an external review.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**. If the appeal does not resolve the matter, you or your authorized representative may request a second level of **appeal** before proceeding to appeal through an external review. Both first and second level **appeals** must be completed within 10 days.

Exhaustion of Process

In some situations you must exhaust the applicable level one and level two processes of the Appeal Procedure before you:

- Contact the Ohio Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Ohio Department of Insurance; or
- Establish any:
  Litigation;
  Arbitration; or
  Administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

Exceptions to the exhaustion of the level one and level two processes of the **Appeals** procedure may occur in the following instances:

a) **Aetna** agrees to waive the Exhaustion requirement;
b) You did not receive a written decision of **Aetna's** internal **appeal** within the required timeframe;
c) **Aetna** fails to meet all requirements of the internal appeals process unless the failure:
    - was *de minimis*;
    - does not cause or is not likely to cause prejudice or harm to you;
    - was for good cause and beyond the control of the Plan; or
    - is not reflective of a pattern or practice of non-compliance.
d) an expedited **external review** is sought simultaneously with an expedited internal review.

An internal **appeal** process shall be considered exhausted if you have requested an internal **appeal** and have not received a written decision from **Aetna** at each level of **appeal** within the timeframes listed above and **Aetna** fails to adhere to all requirements of the internal **appeals** process.

You may not request an **external review** of an **adverse benefit determination** involving a retrospective utilization review decision until **Aetna's** internal **appeal** process has been exhausted unless the **Aetna** agrees to waive the exhaustion requirement

Under certain circumstances, you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

If **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or **appeal** straight to an **External Review**. Your claim or internal **appeal** will not go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.

Glossary

(GR-9N 34-005 01)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

A *(GR-9N-34-005-05)*

Aetna

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

Ambulance

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

Average Wholesale Price (AWP)

The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

B *(GR-9N-34-010-02-OH)*

Behavioral Health Provider/Practitioner

A licensed facility, organization or **other health care** provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, **mental disorder**s or **biologically-based mental illnesses** acting within the scope of the applicable license. This includes:

- **Hospitals**;
- Psychiatric **hospitals**;
- **Physicians**, including those licensed to practice osteopathic medicine and surgery;
- **Residential treatment facilities**;
- **Psychiatric physicians**;
- Psychologists;
- Social workers;
- Psychiatric nurses;
- Clinical nurse specialists whose nursing specialty is mental health;
- Addictionologists;
- Professional counselors;
- Professional clinical counselors;
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

Birthing Center

A freestanding facility that meets ***all*** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.

- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index
This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand-Name Prescription Drug
A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

C *(GR-9N 34-015 02)*

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

Coinsurance Limit
Coinsurance limit is the maximum out-of-pocket amount you are responsible to pay for **coinsurance** for **covered expenses** during your calendar year. Once you satisfy the **coinsurance limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the calendar year. You have a separate **coinsurance limit** for out-of-network expenses and a separate maximum out-of-pocket limit for in-network expenses.

Copay or Copayment
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

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

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this Booklet-Certificate.

Creditable Coverage
A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

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

D *(GR-9N 34-020 06)*

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

Dentist
A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Detoxification *(GR-9N 34-020 06)*

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

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

as determined by a **physician** 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 take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

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

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory

A listing of all **network providers** serving the class of employees to which you belong. The policyholder will give you a copy of this **directory**. **Network provider** information is available through **Aetna's** online provider **directory**, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this **directory**.

Durable Medical and Surgical Equipment (DME)

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

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

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

E *(GR-9N 34-25 09)*

Emergency Admission

An admission to a **hospital** or treatment facility by a **physician** who admits you right after the sudden and, at that time, unexpected onset of an **emergency medical condition** which requires confinement right away as a full-time stay.

Emergency Care

This means the treatment given in a hospital's emergency room to evaluate and treat an **emergency medical condition**, including the following:

- A medical screening examination, as required by federal law, that is within the capability of the hospital's emergency room, including ancillary services routinely available to the emergency room, to evaluate an **emergency medical condition**; and
- Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the **hospital**, including any trauma and burn center of the **hospital**.

As used in the preceding paragraph, the term "stabilize" means, to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Emergency Medical Condition

A medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

Experimental or Investigational

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

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

G *(GR-9N 34-035 01)*

Generic Prescription Drug
A **prescription drug**, that is identified by its:
- chemical;
- proprietary; or
- non-proprietary name; and
- is accepted by the U.S. Food and Drug Administration as therapeutically the same; and
- can be replaced with drugs with the same amount of active ingredient; and
- so stated by Medispan or any other publication named by **Aetna** or consort.

H *(GR-9N 34-040 02)*

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

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

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

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency
An agency that meets all of the following requirements.

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

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

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

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

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

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.

- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

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

Hospice Facility

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

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

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;

- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

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

I *(GR-9N 34-045 02)*

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

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

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

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

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

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

J *(GR-9N 34-050 01)*

Jaw Joint Disorder *(GR-9N 34-050 01)*
This is:

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

L *(GR-9N 34-055 01)*

Late Enrollee
This is an employee in an Eligible Class who asked for enrollment under this Plan after the Initial Enrollment Period. Also, this is an eligible dependent for whom the employee did not choose coverage for the Initial Enrollment Period, but for whom coverage is asked for at a later time.

An eligible employee or dependent may not be considered a **Late Enrollee** at certain times. See the Special Enrollment Periods section of the (Booklet-Certificate).

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

M *(GR-9N-34-065-03 OH)*

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

Maintenance Care
Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Out-of-Pocket Limit
Your plan has a **maximum out-of-pocket limit**. Your **deductibles**, **coinsurance**, **copayments** and other eligible out-of-pocket expense apply to the **maximum out-of-pocket limit**. Once you meet the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the **Calendar Year**. You have a separate **maximum out-of-pocket limit** for network and out-of-network out-of-pocket expenses.

Non-covered expenses and certain **covered expenses** do not apply toward your **maximum out-of-pocket limit**. Please refer to your *Summary of Benefits* for details regarding the type of expenses and specific expenses that are not counted toward your **maximum out-of-pocket limit**.

Medically Necessary or Medical Necessity
These are health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must be:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and

c) Not mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

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

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

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

N *(GR-9N 34-070 02)*

Negotiated Charge *(GR-9N-34-070-11 OH)*

As to health expense coverage, other than Prescription Drug Expense Coverage, this is either:

- The amount a **network provider** has agreed to accept
- The amount **Aetna** agrees 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.**

As to Prescription Drug Expense Coverage:
The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Advanced Reproductive Technology (ART) Specialist

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

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

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

Network Service(s) or Supply(ies)
Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **PCP**.

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

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

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

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

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

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

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

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

Non-Preferred Drug (Non-Formulary)
A **prescription drug** that is not listed in the **preferred drug guide**. This includes **prescription drugs** on the **preferred drug guide exclusions list** that are approved by medical exception.

Non-Specialist
A **physician** who is not a **specialist**.

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

O *(GR-9N-34-075-01 OH)*

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

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

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

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

Orthodontic Treatment *(GR-9N-34-075-01 OH)*
This is any:

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

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

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

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

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

Out-of-Network Service(s) and Supply(ies) *(GR-9N-34-075-01 OH)*
Health care service or supply that is:

- Furnished by an **out-of network provider**; or
- Not furnished or arranged by your **PCP**.

Out-of-Network Provider
A health care provider or **pharmacy** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

P *(GR-9N-34-80-09)*

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

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

Partial Hospitalization Treatment *(GR-9N-34-080-10 OH)*
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. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician
A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

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

Preferred Drug Guide
A listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Preferred Drug Guide Exclusions List
A list of **prescription drugs** in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna**.

Preferred Network Pharmacy
A **network retail pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** that we have identified as a **preferred network pharmacy**.

Prescriber
Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug
A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Physician (PCP)
This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on **Aetna**'s records as the person's **PCP**.

Psychiatric Hospital *(GR-9N-34-080-10 OH)*
This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or **mental disorders (including substance-related disorders)**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**

- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a **physician** who:

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

R *(GR-9N-34-090-01 OH)*

Recognized Charge *(GR-9N-34-090-17)*

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.

In all cases, the **recognized charge** is determined based on the Geographic Area where you receive the service or supply.

Recognized charge does not apply to involuntary services.
Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider** bills and:

- For professional services and for other services or supplies not mentioned below:
  - 300% of the Medicare allowable rate

- For services of **hospitals** and other facilities:
  - 300% of the Medicare allowable rate

- For **prescription drugs**:
  - 110% of the Average wholesale price (AWP)

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.** Except for involuntary services, when you get care from a NAP **provider** your **out-of-network** cost sharing applies.

We have the right to apply **Aetna** reimbursement policies. Those policies may further reduce the **recognized charge.** These policies take into account factors such as:

- 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 incidental to the primary service provided and
- The educational level, licensure or length of training of the **provider**

Aetna 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 and
- The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used
Average wholesale price (AWP), Geographic area, Involuntary services, and Medicare allowable rates are defined as follows:

Average wholesale price (AWP)
Is the current average wholesale price of a **prescription drug** listed in the Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).

Geographic area
The Geographic area made up of 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
Involuntary services are services or supplies that are:

- Performed at a **network** facility by an **out-of-network provider,** unless that **out-of-network provider** is an assistant surgeon for your surgery, or
- Not available from a **network provider**, or
- **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 allowable rates
Except as specified below, these 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 will determine the rate as follows:

- Use the same method CMS uses to set Medicare rates.
- Look at what other providers charge.
- Look at how much work it takes to perform a service.
- Look at other things as needed to decide what rate is reasonable for a particular service or supply.

Additional information:
Get the most value out of your benefits. Use the "Estimate the Cost of Care" tool on Aetna Navigator® to help decide whether to get care in network or out-of-network. **Aetna's** secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

Rehabilitation Facility
A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

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

Residential Treatment Facility (Mental Disorders) *(GR-9N-34-090-17)*

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

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Residential Treatment Facility (Substance Abuse)

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

- Has, on site, licensed **behavioral health provider**, medical or alcoholism or drug abuse health care providers 24 hours per day;
- Provides a comprehensive patient assessment;
- Has the ability to assess and recognize withdrawal complications that threaten life or bodily functions, and to obtain needed services either on-site or externally;
- Has 24 hour supervision with evidence of close and frequent observation;
- Has medical treatment available, actively supervised by an attending **physician** or **psychiatric physician**;
- Provides living arrangements that foster community living and peer interaction and are consistent with developmental needs;
- Offers group therapy sessions;
- Has the ability to involve family and other support systems in therapy;
- Has individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Provides a level of skilled intervention consistent with patient risk;
- Provides active discharge planning initiated upon admission to the program;
- Can make referrals to, or has a connection with appropriate alcoholism and drug abuse programs during residential treatment, and following discharge;
- Meets any applicable licensing standards established by the jurisdiction in which it is located;
- Charges patients for its services.

R.N.

A registered nurse.

Room and Board

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

S *(GR-9N 34-95-10)*

Self-injectable Drug(s)
Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

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

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

Skilled Nursing Facility
An institution that meets all of the following requirements:

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

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

Skilled nursing facility does not include:

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

Skilled Nursing Services
Services that meet all of the following requirements:

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

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

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

Specialty Care Drugs
Injectable, infusion and oral **prescription drugs** that are prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis.
You can access the list of these **specialty care prescription drugs** by calling the toll-free number on your Member ID card or by logging on to your Aetna Navigator® secure member website at www.aetna.com

Specialty Pharmacy Network
A network of pharmacies designated to fill **specialty care drugs**.

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

Step Therapy
A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

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

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

Must have all of the following:

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

Substance Abuse *(GR-9N 34-095-11 OH)*

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

T *(GR-9N 34-100-06)*

Telemedicine *(GR-9N 34-100 09)*

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service.

Services can be provided by:

- Two-way audiovisual teleconferencing
- Telephone calls, except for behavioral health services
- Any other method required by state law

Terminally Ill (Hospice Care)

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

Therapeutic Drug Class

A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

U *(GR-9N 34-105 02 OH)*

Urgent Admission

A **hospital** admission by a **physician** due to:

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

Urgent Care Facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Charges for its services and supplies.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician**'s office, but only one that:
  - Has contracted with **Aetna** to provide urgent care; and
  - Is, with **Aetna**'s consent, included in the **directory** as a network **urgent care provider**.

It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

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

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

W *(GR-9N 34-110 01)*

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. They are an alternative to a **physician's** office visit for:

- treatment of unscheduled;
- non-emergency **illnesses;** and
- **Injuries;** and
- the administration of certain immunizations.

It is not an alternative for emergency room services or the ongoing care provided by a **physician**. Neither an emergency room, nor the outpatient department of a **hospital**, shall be considered a **Walk-in Clinic**.

AETNA LIFE INSURANCE COMPANY

Patient Protection and Affordable Care Act *of 2010*

AMENDMENT
(GR-9N-PPACA-NG/PPO 01 OH)

This Amendment amends your health benefit plan (Plan), and becomes a part of your Plan as of January 1, 2018, the Effective Date. Please place this Amendment with your Certificate of Coverage for future reference.

On the Effective Date of this **Amendment,** certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010.

Regardless of the terms and conditions of any other provisions of your Plan, this **Amendment** will control.

The following Definition is added to your Plan:
"Essential Health Benefits" is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Your plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this **Amendment.**

Emergency Services
"Stabilize" means, to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department. Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from an out of network provider. However, an out of network provider of Emergency Services may send you a bill for any charges remaining after your Plan has paid (this is called "balance billing").

Except where your Plan provides a better benefit, your Plan will apply the same copayments and coinsurance for out of network Emergency Services as it generally requires for in network Emergency Services. A deductible may be imposed for out of network Emergency Services, only as part of the deductible that generally applies to out of network benefits. Similarly, any out-of-pocket maximum that generally applies to out of network benefits will apply to out of network Emergency Services.

Your Plan will calculate the amount to be paid for out of network Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount your Plan pays to in network providers for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with in-network providers for the services furnished); 2) the amount that would be paid using the same method your Plan generally uses to determine payment for out of network services (such as the usual, customary and reasonable charges), but substituting in network copayments and coinsurance amounts; and (3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any in network copayments or coinsurance.

Lifetime Dollar Limits
The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan's terms, and that Plan is still in effect, you will receive a notice that the lifetime dollar limit no longer applies and that you will have an opportunity to enroll or be reinstated under your Plan. If you are eligible for this enrollment opportunity, you will be treated as a special enrollee.

Annual Dollar Limits
Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. Your Plan may include other benefits not defined as Essential Health Benefits, and those other benefits may have annual dollar limits. If your Plan has annual dollar limits on Essential Health Benefits they are subject to the following:

For a plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit can be no less than $750,000.

For a plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit can be no less than $1.25 million.

For a plan year beginning on or after September 23, 2012, but before December 31, 2013, the limit can be no less than $2 million.

For a plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan.

Rescission of Coverage
A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

Preventive Health Benefits
Under Ohio law, the following preventive health benefits are required to be provided in your Plan:

- Initial Mammography starting at age 35
- Annual screening for cervical cancer
- Child Health Supervision

Your Plan provides additional coverage for selected preventive services without a copayment, coinsurance or deductible when these services are delivered by a network provider.

Depending upon your age, services may include:

- Screenings and tests for diseases
- Mental Health screenings, including substance abuse
- Healthy lifestyle counseling
- Vaccines and immunizations
- Pregnancy counseling and screenings
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Please contact us at www.aetna.com or the telephone number shown on your Member ID card, if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/center/regulations/prevention.html.

Dependent Coverage (for plans that make dependent coverage available)
This Plan will cover your married or unmarried child as defined in Eligibility and Enrollment section of this Plan until your child reaches age 26.

Your Plan will provide coverage, or offer you the opportunity to purchase coverage, for your unmarried natural child, stepchild, or adopted child until your child reaches age 28 if your child is (1) a resident of Ohio or a full-time student at an accredited public or private institution of higher education; and (2) not employed by an employer who offers any health benefit plan under which your child is eligible for coverage; and (3) not eligible for Medicaid or Medicare.

Internal Claims and Appeals and External Review Process

Definitions

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

Such **adverse benefit determination** may be based on:

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

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

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

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

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

External Review: A review of an adverse benefit determination or a final adverse benefit determination by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner made up of physicians or other appropriate health care providers. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An adverse benefit determination that has been upheld by the Plan at the exhaustion of the appeals process.

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

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

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

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

Full and Fair Review of Claim Determinations and Appeals

The Plan will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the final adverse benefit determination is required to be provided so that you may respond prior to that date.

Prior to issuing a final adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of final adverse determination is required.

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. If the Plan makes an adverse benefit determination, written notice will be provided to you, or in the case of a concurrent care claim, to your provider.

Urgent Care Claims

The Plan will make notification of an urgent care claim determination as soon as possible but not more than 24 hours after the claim is made.

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

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

Pre-Service Claims

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

Post-service Claims

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

Concurrent Care Claim Extension

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

Concurrent Care Claim Reduction or Termination

The Plan will notify you of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

If you file an appeal, coverage under the plan will continue for the previously approved or ongoing course of treatment until a final appeal decision is rendered. During this continuation period, you are responsible for any copayments; coinsurance; and deductibles; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under appeal. If the Plan's initial claim decision is upheld in the final appeal decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints

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

Appeals of Adverse Benefit Determinations

You may submit an appeal if the Plan gives notice of an adverse benefit determination. This Plan provides for one level or two levels of appeal. A final adverse benefit determination notice will also provide an option to request an External Review.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your Level One Appeal. Your appeal must be submitted in writing and must include:

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

Send your written appeal to Member Services at the address shown on your ID Card.

You may also choose to have another person (an authorized representative) make the appeal on your behalf. You must provide written consent to the Plan.

You may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Level One Appeal

A review of a Level One Appeal of an adverse benefit determination shall be provided by Plan personnel. They shall not have been involved in making the adverse benefit determination..

Urgent care claims (May Include concurrent care claim reduction or termination.)
The Plan shall issue a decision within 36 hours of receipt of the request for an appeal.

Pre-service claims (May Include concurrent care claim reduction or termination.)
The Plan shall issue a decision within 15 calendar days of receipt of the request for an appeal.

Post-Service Claims
The Plan shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Level Two Appeal

If the Plan upholds an adverse benefit determination at the first level of appeal, and the reason for the decision was based on medical necessity or experimental or investigational reasons, you or your authorized representative have the right to file a Level Two Appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a Level One Appeal.

Review of a Level Two Appeal of an adverse benefit determination of an urgent care claim, a Pre-Service Claim, or a Post-Service Claim shall be provided by Plan personnel. They shall not have been involved in making the adverse benefit determination.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination.)

The Plan shall issue a decision within 24 hours of receipt of the request for a Level Two Appeal.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination.)

The Plan shall issue a decision within 15 calendar days of receipt of the request for Level Two Appeal.

Post-Service Claims

The Plan shall issue a decision within 30 calendar days of receipt of the request for a Level Two Appeal.

Exhaustion of Process

You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- contact the Ohio Department of Insurance to request an investigation of a complaint or appeal; or
- file a complaint or appeal with the Ohio Department of Insurance; or
- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna; or any matter within the scope of the Appeals Procedure.

Under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and External Review processes—these include Urgent Care Claims and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:
If the Plan does not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the appeal requirements and may proceed with External Review or any of the actions mentioned above.

You or an authorized person may contact the Ohio Department of Insurance in writing to request a review if you have been denied coverage of a health care service on the grounds that the service is not a Covered Medical Expense under the Plan. The Ohio Department of Insurance shall determine whether the health care service is a Covered Medical Expense under the Plan. The Ohio Department of Insurance will notify you and the Plan of its determination or that it is not able to make a determination because the determination involves whether or not the health care service is necessary.

If the determination is based on whether the health care service is necessary you have a right to an External Review.

You can contact the Department of Insurance by writing to 50 W. Town Street, Third Floor Suite 300, Columbus, Ohio 43215 or by calling the Department at 800-686-1526.

External Review

The Plan shall afford you an opportunity for an External Review for a coverage denial when requested by you or an authorized person if:

- The Plan has determined that the health care service is not necessary.
- The service, plus any ancillary services and follow-up care, will cost you more than $500.00.

The Plan does not need to afford External Review if:

- The Department of Insurance has determined that the health care service is not a Covered Medical Expense under the Plan.
- You fail to exhaust Aetna's Appeals Procedure.
- No new clinical information has been submitted to the Plan for a previous External Review for the same denial of coverage.

Your request for External Review must be made within 60 days after receipt of notice from the Department of Insurance of the Plan upholding a denial of coverage. External Review may be requested by you, your authorized person, your provider, or a health care facility rendering health care service to you.

External Review must be requested in writing. Expedited review may be requested orally or by electronic means. Written confirmation must be submitted to the Plan within 5 days after the request is made.

For an expedited review, your provider must certify that your condition could, in the absence of immediate medical attention, result in any of the following:

- Placing your health, or with respect to a pregnant woman, the health of your or the unborn child, in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

External Review Procedure for Terminal Illness

The Plan has an External Review process for coverage decisions for you if all of the following apply:

- You have a terminal condition that has a high probability of causing death with 2 years.
- You request a review within 60 days of receipt of notice from the Department of Insurance that determination requires resolution of medical necessity.
- Your physician certifies the terminal condition.
- Standard therapies have not been effective, are not necessary, or no standard therapies covered under the Plan is more beneficial for your condition.
- Your physician recommends a drug, device, procedure, or other therapy that is likely to be more beneficial than standard therapy; or you request a therapy found in peer-reviewed published studies to have effective clinical outcomes for the same condition.
- You have exhausted the Plan's Appeals Procedure.
- The drug, device, procedure, or other therapy, for which coverage has been denied would be covered under the Plan except for the Plan's determination that the treatment if experimental or investigational.

The External Review shall be conducted by an independent review organization assigned by the Ohio Department of Insurance.

You are not required to pay any part of the cost of the review. The cost of the review shall be borne by the Plan.

The independent review organization shall issue a written decision no later than 30 days (7 days for an expedited review) after the filing of the request for review.

The Plan shall provide any coverage determined by the independent review organization to be necessary, subject to the terms, limitations, and conditions of the plan.

For more information about the External Review process, call the toll-free Member Services telephone number shown on your ID card.

No Preexisting Condition Limitations for Members under age 19

The Preexisting Condition Limitations described in the Exclusion and Limitations Section of your Plan do not apply to members who are under 19 years of age. With respect to members who are under 19 years of age, your Plan covers any condition that may have been previously excluded by name or specific description as a pre-existing condition. This also means a member under the age of 19 cannot be excluded from the plan if the exclusion is based on a preexisting condition.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from us or any other person (including a primary care physician) 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 **Aetna** at the telephone number shown on your Member I.D. card.

Selection of a Primary Care Physician

We generally allow the designation of a primary care physician. You have the right to designate any primary care physician who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care physician.

For information on how to select a primary care physician, and for a list of the participating primary care physicians, call Member Services at the number shown on your I.D. card.

This Amendment takes effect on the later of the effective date of the Plan to which it is attached, or January 1, 2018. This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

IN WITNESS WHEREOF:

AETNA LIFE INSURANCE COMPANY
(A Stock Company)

Mark T. Bertolini
Chairman, Chief Executive Officer and President

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.

Additional Information Provided by

URS | CH2M Oak Ridge LLC (UCOR)

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Please see your Plan Administrator for this information.

Employer Identification Number:
45-217-8216

Plan Number:
510

Type of Plan:
Group Welfare Benefit Plan

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Sponsor:
URS | CH2M Oak Ridge LLC (UCOR)
P.O. Box 4699
MS 7020, K-1007
Oak Ridge, TN 37831
865-576-9206

A complete list of employers and employee organizations sponsoring each plan may be obtained by participants and beneficiaries upon request to the Plan Administrator, and is available for examination by participants and beneficiaries by contacting the Plan Administrator. Further, participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the plan, and if the employer is a plan sponsor, the plan sponsor's address.

Plan Administrator:
The plan is administered through the Benefits and Investments Committee. The Committee has delegated day-to-day administration of the plan to:
URS | CH2M Oak Ridge LLC (UCOR)
P.O. Box 4699
MS 7020, K-1007
Oak Ridge, TN 37831
865-576-9206

Agent For Service of Legal Process:

CT Corporation Systems
800 South Gay Street, Suite 2021
Knoxville, TN 37929

CT Corporation Systems
Kentucky Home Life Building
Louisville, KY 40202

CT Corporation Systems
1300 East 9th Street
Cleveland, OH 44114

Service of legal process may also be made on the Plan Administrator or Plan Trustee.

***Plan Trustee*:**
Sun Trust Bank, East, TN-0547.
P.O. Box 4655
25 Park Place, MC 210
Atlanta, GA 30302

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by individual authorized by the Board of Directors of URS | CH2M Oak Ridge LLC (UCOR).

The Plan is maintained in accordance with health and welfare provisions of a collective bargaining agreement.

ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

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

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

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

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to recent changes to preventive services coverage and women's preventive health coverage under the Federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of the ACA.

The following is a summary of the recent changes to preventive services coverage and women's preventive health coverage under the ACA that applies to non-grandfathered plans that are not otherwise exempt from the requirements. Preventive services, as required by ACA, will be paid without cost-sharing such as payment percentages, copays and deductibles.

For details on any benefit maximums and the cost sharing under your plan, call the Member Services number on the back of your ID card.

1. An annual routine physical exam for covered persons through age 21.

2. For covered females:
   - Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
     - Screening and counseling services, such as:
       - Interpersonal and domestic violence;
       - Sexually transmitted diseases; and
       - Human Immune Deficiency Virus (HIV) infections.
     - Screening for gestational diabetes.
     - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once - three years.
   - A routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration.

3. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
   - Preventive counseling visits and/or risk factor reduction intervention;
   - Medical nutrition therapy;
   - Nutritional counseling; and
   - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

   Benefits under your plan may be subject to visit maximums.

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

   Benefits under your plan may be subject to visit maximums.

5. Screening and counseling services to aid you to stop the use of tobacco products. Coverage includes:
   - Preventive counseling visits;
   - Treatment visits; and
   - Class visits.

   Benefits under your plan may be subject to visit maximums.

6. Prenatal care received by a pregnant female. Coverage is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

7. Comprehensive lactation support, (assistance and training in breast feeding), and counseling services provided by a certified lactation support provider, in a group or individual setting, to females during pregnancy and in the post partum period.

   The rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk), and the purchase of the accessories and supplies needed to operate the item. Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

   Benefits under your plan may be subject to maximums.

8. For females with reproductive capacity, coverage includes:
   - FDA-approved contraceptive methods including certain FDA-approved generic drugs, implantable devices, sterilization procedures and patient education and counseling for women with reproductive capacity.
   - Counseling services provided by a physician in either a group or individual setting on contraceptive methods. Benefits may be subject to visit maximums.
   - Female voluntary sterilization procedures and related services and supplies including tubal ligation and sterilization implants. Coverage does not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.
   - FDA-approved female generic emergency contraceptive methods that are prescribed by your physician. The prescription must be submitted to the pharmacist for processing.

   Additional exemptions may apply to plans that are sponsored by religious employers or religious organizations and meet certain criteria which exempt the health plan from the federal requirement to provide coverage for contraceptive services.

   The drug list is subject to change. Visit "Medication Search" on your secure member website at www.aetna.com for the most up-to-date information on drug coverage for your plan.

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.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that for new plans on or after January 1, 2014, and for non-grandfathered plans that renew on a date on or after January 1, 2014, Aetna is administering medical and outpatient prescription drug coverage in compliance with the following applicable components of the ACA.

The following is a summary of the recent changes under the ACA.

For details on any benefit maximums and the cost sharing under your plan, log onto the Aetna website www.aetna.com, call the Member Services number on the back of your ID card, or refer to the Summary of Benefit and Coverage document you have received.

1. Subject to any allowed applicable age, family history and frequency guidelines for preventive services covered under the plan, (which may be in-network only for plans that use a provider network) the following services are included in those considered preventive:

    - Coverage of comprehensive lactation support and counseling, and the costs of renting or purchasing breastfeeding equipment extended for the duration of breastfeeding.
    - In accordance with the recommendations of the United States Preventive Services Task Force, and when prescribed by a physician:
        i. aspirin for men and women age 45 and over;
        ii. folic acid for women planning or capable of pregnancy;
        iii. routine iron supplementation for asymptomatic children ages 6 to 12 months;
        iv. vitamin D supplementation for men and women age 65 and older;
        v. fluoride supplementation for children from age 6 months through age 5;
        vi. genetic counseling, evaluation and lab tests for routine breast cancer susceptibility gene (BRCA) testing;
        vii. Food and Drug Administration (FDA) approved female over-the-counter contraceptives, and an office visit for contraceptive administration and/or removal of a contraceptive device

2. Any annual or lifetime dollar maximum benefit that applies to "Essential Health Benefits" (as defined by the ACA and included in the plan) no longer applies. Essential Health Benefits will continue to be subject to any coinsurance, copays, deductibles, other types of maximums (e.g., day and visit maximums), referral and certification rules, and any exclusions and limitations that apply to these types of covered medical expenses under your plan.

3. If your Plan includes a pre-existing condition limitation or exclusion provision, including one that may apply to transplant coverage, then this limitation or exclusion no longer applies.

4. If your Plan includes a waiting or probationary period, (the period of time that must pass before your coverage can become effective), this period of time cannot be greater than 90 days.

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 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 FMLA 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.

With respect to Kentucky Employees:

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal and/or State Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by the Family and Medical Leave Act of 1993 ("FMLA") or leave required by Kentucky Rev. Stat. § 337.015 for the reception of an adoptive child under the age of seven ("Kentucky Adoption Leave Statute") If your Employer grants you approved FMLA and/or Kentucky Adoption Leave Statute leave for a period in excess of the period required by FMLA or Kentucky Adoption Leave Statute, 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 approved FMLA and/or Kentucky Adoption Leave Statute leave in accordance with FMLA and/or the Kentucky Adoption Leave Statute, you may, during the continuance of such approved FMLA and/or Kentucky Adoption Leave Statute 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 have reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA and/or Kentucky Adoption Leave Statute 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 and/or Kentucky Adoption Leave Statute leave is terminated; or
- 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 and/or Kentucky Adoption Leave Statute 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 and/or Kentucky Adoption Leave Statute 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 approved FMLA and/or Kentucky Adoption Leave Statute 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 approved FMLA and/or Kentucky Adoption Leave Statute leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA and/or Kentucky Adoption Leave Statute leave is terminated, your coverage under the group contract will be in force as though you had continued active employment rather than going on an approved FMLA and/or Kentucky Adoption Leave statute leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA and/or Kentucky Adoption Leave Statute 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 and/or Kentucky Adoption Leave Statute 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 and/or Kentucky Adoption Leave Statute leave is terminated.

With respect to Ohio Employees:

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 the Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you 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 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 have 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; or
- 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 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 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 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.

With respect to Tennessee Employees:

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal and/or State Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by the Family and Medical Leave Act of 1993 (FMLA) or the Tennessee Maternity Leave Act ("TMLA"). If your Employer grants you approved FMLA and/or TMLA leave for a period in excess of the period required by FMLA or TMLA, 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 approved FMLA and/or TMLA leave in accordance with FMLA and/or TMLA, you may, during the continuance of such approved FMLA and/or TMLA 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 have reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA and/or TMLA 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 and/or TMLA leave is terminated; or
- 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 and/or TMLA 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 and/or TMLA 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 approved FMLA and/or TMLA 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 approved FMLA and/or TMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA and/or TMLA leave is terminated, your coverage under the group contract will be in force as though you had continued active employment rather than going on an approved FMLA and/or TMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA and/or TMLA 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 and/or TMLA 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 and/or TMLA leave is terminated.

Schedule of Benefits

(GR-9N-S-01-001-01 OH)

Employer: **URS | CH2M Oak Ridge LLC (UCOR)**

Group Policy Number: **GP-720018**

Issue Date: March 10, 2018
Effective Date: January 1, 2018
Schedule: 6A
Cert Base: 6

For: Open Access Managed Choice Consumer Directed Health Plan Qualified High Deductible Health Plan (HDHP) - All Active Participating Employers and Eligible Employees - CDHP Plan

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Open Access Plan *(GR-9N 11-005 OH)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$2,700	$5,000
Family Deductible*	$5,400	$10,000

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan deductible, prescription drugs and copayments.

Plan Maximum Out of Pocket Limit excludes precertification penalties.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $6,550.
- For **out-of-network** expenses: $13,100.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $13,100.
- For **out-of-network** expenses: $26,200.

Lifetime Maximum Benefit per person	Unlimited	Unlimited

(GR-9N 10-016 05)

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, and the remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Preventive Care		
Routine Physical Exams ***Office Visits***	100% per visit No **copay** or **deductible** applies.	50% per visit after Calendar Year **deductible**

(GR-9N 10-016 05)

Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card*
Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive months	1 visit	1 visit
Covered Persons age 65 and over: Maximum Visits per 12 consecutive months	1 visit	1 visit

(GR-9N S 10-016 04 NG OH)

Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit No **copay** or **deductible** applies. Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.*	50% per visit after Calendar Year **deductible** Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.*

Screening & Counseling Services ***Office Visits*** ***-Obesity and/or Healthy Diet*** ***-Misuse of Alcohol and/or Drugs*** ***-Use of Tobacco Products*** ***-Sexually Transmitted Infections*** ***-Genetic Risk for Breast and Ovarian Cancer*** *(GR-9N S 10-016 04 NG OH)*	100% per visit No **copay** or **deductible** applies.	50% per visits after Calendar Year **deductible**

Obesity and/or Healthy Diet Benefit Maximums		
Maximum Visits per 12 consecutive months *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* *****	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* *****

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.
(GR-9N S 10-016 04 NG OH)

Misuse of Alcohol and/or Drugs		
Maximum Visits per 12 consecutive months	5 visits*	5 visits*

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.
(GR-9N S 10-016 04 NG OH)

Use of Tobacco Products Maximum Visits per 12 consecutive months	8 visits*****	8 visits*****

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.
(GR-9N S 10-016 04 NG OH)

Sexually Transmitted Infections Benefit Maximums Maximum Visits per 12 consecutive months	2 visits*****	2 visits*****

Note:** ***In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.

Well Woman Preventive Visits ***Office Visits*** Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administration	100% per visit No **copay** or Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**

Well Woman Preventive Visits Maximum Visits per Calendar Year	1 visit	1 visit

Routine Cancer Screening *(GR-9N S 10-016 04 NG OH)*		
***Outpatient:* Baseline Mammogram**	100% per visit No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**
Maximum	One baseline mammogram for women age 35 but less than age 40.	One baseline mammogram for women age 35 but less than age 40.
***Outpatient:* All Other Mammograms**	100% per visit No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**.
Maximum for women at age 40	1 mammogram per Calendar Year	1 mammogram per Calendar Year
Outpatient: All Other Routine Cancer Screenings	100% per visit No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**.

(GR-9N S 10-016 04 NG OH)

Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • 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; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician,** log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Subject to any age; family history; and frequency guidelines as set forth in the most current: • 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; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician,** log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*
Lung Cancer Screening Maximum	One screening every 12 months*.	One screening every 12 months*.
*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing of your Schedule of Benefits.		

Prenatal Care		
Office Visits *(GR-9N S 10-016 04 NG OH)*	100% per visit No **copay** or **deductible** applies.	50% per visit after Calendar Year **deductible.**
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.		

Comprehensive Lactation Support and Counseling Services *(GR-9N S 10-016 04 NG OH)*		
Lactation Counseling Services *Facility or Office Visits*	100% per visit No **copay** or **deductible** applies.	50% per visit after Calendar Year **deductible**
(GR-9N S 10-016 04 NG OH)		
Lactation Counseling Services Maximum Visits per 12 consecutive months either in a group or individual setting	6* visits	Not Applicable
***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits.*		

(GR-9N S 10-016 04 NG OH)		
Breast Pumps & Supplies	100% per item. No **copay** or **deductible** applies.	50% per item after Calendar Year **deductible**
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.		

(GR-9N S 10-016 04 NG OH)

Family Planning Services		
Female Contraceptive Counseling Services -Office Visits.	100% per visit. No **copay** or **deductible** applies.	50% per visit after Calendar Year **deductible**

(GR-9N S 10-016 04 NG OH)

Contraceptive Counseling Services - Maximum Visits per 12 consecutive months either in a group or individual setting	2* visits	Not Applicable

*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Family Planning Services - Female Contraceptives *(GR-9N S 10-016 04 NG OH)*

Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits.	100% per item. No **copay** or **deductible** applies.	50% per item after Calendar Year **deductible**

Family Planning Services - Female Voluntary Sterilization *(GR-9N S 10-016 04 NG OH)*

Inpatient	100% per admission. No **copay** or **deductible** applies.	50% per admission after Calendar Year **deductible**
Outpatient	100% per visit/surgical procedure. No **copay** or **deductible** applies.	50% per visit/surgical procedure after Calendar Year **deductible**

Family Planning – Other		
Voluntary Termination of Pregnancy		
Outpatient	50% per visit/surgical procedure after Calendar Year **deductible.**	50% per visit/surgical procedure after Calendar Year **deductible.**
Voluntary Sterilization for Males		
Outpatient	50% per visit/surgical procedure after Calendar Year **deductible.**	50% per visit/surgical procedure after Calendar Year **deductible.**

Preventive Care Drugs and Supplements	
Preventive care drugs and supplements filled at a retail **pharmacy** for each 30 day supply. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.	100% per item No **copay** or **deductible** applies.
Tobacco Cessation Prescription and Over-the-Counter Drugs	
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply. Maximums: Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.	100% per item No **copay** or **deductible** applies.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Vision Care *(GR-9N-S-11-020-01)*		
Eye Examinations including refraction	100% per exam No Calendar Year **deductible** applies.	50% per exam after Calendar Year **deductible**
Maximum Benefit per 24 consecutive month period	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services *(GR-9N 11-025 05 OH)*		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Specialist Office Visits	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Walk-in Clinics Non-Emergency Visit	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Administration of Anesthesia	50% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**
Allergy Testing and Treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	50% per visit after Calendar Year **deductible**
Allergy Injections	Payable in accordance with the type of expense incurred and the place where service is provided.	50% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services *(GR-9N-S-11-030-05 OH)*		
Hospital Emergency Facility and Physician	50% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible** See Important Note Below

Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **coinsurance)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered
Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.
Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	Not covered	Not covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic and Preoperative Testing *(GR-9N-11-035 01 OH)*		
Complex Imaging Services		
Complex Imaging	50% per test after Calendar Year **deductible**	50% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	50% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	50% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Surgery *(GR-9N-11-040-01 OH)*		
Outpatient Surgery	50% per visit/surgical procedure after Calendar Year **deductible**	50% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Facility Expenses *(GR-9N-11-045 01 OH)*		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	50% per admission after Calendar Year **deductible**

Hospital Facility Expenses Room and Board (including maternity)	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Other than Room and Board	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	60 days	60 days

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Specialty Benefits *(GR-9N-11-050-01 OH)*		
Home Health Care (Outpatient)	50% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	60 visits	60 visits
Skilled Nursing Care (Outpatient)	50% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment *(GR-9N S-11-55-01)*		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with type of expense incurred. Refer to the Physician Services and other sections of this Schedule to determine what the plan pays.	Payable in accordance with type of expense incurred. Refer to the Physician Services and other sections of this Schedule to determine what the plan pays.

Comprehensive Infertility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Artificial Insemination Maximum Benefit	6 courses of treatment per lifetime	6 courses of treatment per lifetime
Ovulation Induction Maximum Benefit	6 courses of treatment per lifetime	6 courses of treatment per lifetime

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Treatment of Mental Disorders *(GR-9N-S-11-062-01)*		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Other than Room and Board	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Physician Services	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	50% after Calendar Year **deductible**	50% after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders		
Outpatient Services	50% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Other than Room and Board	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Physician Services	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Outpatient Treatment of Substance Abuse		
Outpatient Treatment	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses *(GR-9N S-11-065-01 OH) (GR-9N-11-080-01 OH)*			
Transplant Facility Expenses	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses *(GR-9N-11-080-01 OH)*		
Acupuncture in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.	50% per visit after Calendar Year **deductible**
Ground, Air or Water Ambulance	50% after Calendar Year **deductible**	50% after Calendar Year **deductible**

Durable Medical and Surgical Equipment	50% per item after the Calendar Year **deductible**	50% per item after the Calendar Year **deductible**
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	50% per item after the Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) *(GR-9N-11-080-01 OH)*	Payable in accordance with the type of expense incurred and the place where service is provided.	50% per visit after Calendar Year **deductible**
Orthotic and Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	50% per visit after Calendar Year **deductible**
Clinical Trial Therapies *(GR-9N S 10-016 04 NG OH)* (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Routine Patient Costs	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies *(GR-9N S-11-090-01 OH)*		
Chemotherapy	50% after Calendar Year **deductible**	50% after Calendar Year **deductible**
Infusion Therapy	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Radiation Therapy	50% after Calendar Year **deductible**	50% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies *(GR-9N-11-095-01 OH)*		
Outpatient Physical, Occupational and Speech Therapy combined	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	40 visits	40 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation *(GR-9N-11-095-01 OH)*		
	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder Treatment *(GR-9N S-10-061-07 OH)* Includes pharmacy coverage for treatment when a pharmacy plan is not elected by the contract holder.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.
Autism Spectrum Disorder Diagnosis and Testing	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.
Applied Behavior Analysis	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Physical Therapy Associated with Diagnosis of Autism Spectrum Disorder	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Visit limit per Calendar Year	Unlimited visits	Unlimited visits
Occupational Therapy Associated with Diagnosis of Autism Spectrum Disorder	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Visit limit per Calendar Year	Unlimited visits	Unlimited visits
Speech Therapy Associated with Diagnosis of Autism Spectrum Disorder	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Visit limit per Calendar Year	Unlimited visits	Unlimited visits
Maximum Applied Behavioral Analysis benefit including clinical therapeutic intervention.	Unlimited hours per week.	Unlimited hours per week.

Note: If the calendar year deductible is waived for a service or supply, you pay the copayment or coinsurance amount shown, above for the service or supply until the waiver amount is reached. After the waiver amount is reached, you are responsible to pay the calendar year deductible until it has been met

Pharmacy Benefit *(GR-9N-S-26-005-01)*

Copays/Deductibles *(GR-9N S-26-011 01) (GR-9N S-26-013 01) (GR-9N S-26-016 01)*

PER PRESCRIPTION COPAY/DEDUCTIBLE	**NETWORK**	**OUT-OF-NETWORK**
Preferred Generic Prescription Drugs		
For each initial 90 day supply filled at a retail **pharmacy**	30% of the **negotiated charge** Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**	30% of the **recognized charge** Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy**	30% of the **negotiated charge**	Not Applicable
Preferred Brand-Name Prescription Drugs		
For each initial 90 day supply filled at a retail **pharmacy**	30% of the **negotiated charge** Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**	30% of the **recognized charge** Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**
For all fills of at least a 31 day supply and up to a 90 day supply filled at a **mail order pharmacy** or a CVS/pharmacy	30% of the **negotiated charge**	Not Applicable
Non-Preferred Generic and Brand-Name Prescription Drugs		
For each initial 90 day supply filled at a retail **pharmacy**	45% of the **negotiated charge** Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**	45% of the **recognized charge** Oral Chemotherapy: Lesser of **prescription copay** or Specialist Office Visit **copay**
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy**	45% of the **negotiated charge**	Not Applicable

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If you request a covered brand-name **prescription drug** where a **generic prescription drug** equivalent is available you will be responsible for the cost difference between the **brand-name prescription drug** and the **generic prescription drug** equivalent, plus the applicable cost sharing.

(GR-9N S 26-023 02 NG OH)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
FDA-Approved Female Generic Over-the-Counter Contraceptives For each 30 day supply filled at a retail **pharmacy**	100% per supply No **copay** or **deductible** applies.	Not Covered.
FDA-Approved Female Generic Emergency Over-the-Counter Contraceptives	100% per supply No **copay** or **deductible** applies.	Not Covered.

Important Note:
This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the Aetna website at www.aetna.com or calling the toll-free number on the back of the ID card.

Preventive Care Drugs and Supplements *(GR-9N S26-024-01 NG OH)*		
Preventive care drugs and supplements filled at a **pharmacy** with a **prescription**: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.	100% per item. No **copay** or **deductible** applies.	Not Covered.

Important Note:
Refer to the Booklet and the *Preventive Care* section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.

Tobacco Cessation Prescription and Over-the-Counter Drugs *(GR-9N 26-024 01 OH)* Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply. Maximums: Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.	100% per supply No **copay** or **deductible** applies.	Not Covered.

Coinsurance

	NETWORK	**OUT-OF-NETWORK**
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	50% of the **recognized charge**

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Precertification and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

Expense Provisions *(GR-9N-S-09-05-01 OH)*

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Deductible Provisions *(GR-9N-S-09-05-01 OH)*

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

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

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

Covered expenses that are subject to the **deductibles** include covered expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Network Family Deductible Limit
When you incur **network covered expenses** that apply toward the **network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **network** Calendar Year family **deductible** limit. Your **network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **network** family **deductible** limit in a Calendar Year.

Out-of-Network Family Deductible Limit
When you incur **out-of-network covered expenses** that apply toward the **out-of-network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **out-of-network** Calendar Year family **deductible** limit. Your **out-of-network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **out-of-network** family **deductible** limit in a Calendar Year.

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

Covered expenses that are subject to the **deductibles** include covered expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Copayments and Benefit Deductible Provisions *(GR-9N-S-09-015-01 OH)*

Copayment, Copay
This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

Coinsurance Provisions *(GR-9N S-09-020 01)*

Coinsurance
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "**Plan Coinsurance**". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The **coinsurance** percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

Maximum Out-of-Pocket Limit
The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Maximum Out-of-Pocket Limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Maximum Out-of-Pocket Limit** applies to network benefits.

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

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

The **Maximum Out-of-Pocket Limit** applies to both network and out -of-network benefits. Covered expenses applied to the out-of-network **Maximum Out-of-Pocket Limits** will be applied to satisfy the in-network. **Maximum Out-of-Pocket Limit** and **covered expenses** applied to the in-network will be applied to satisfy the out-of-network **Maximum Out-of-Pocket Limit**.

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction *(GR-9N S-09-30 01-OH)*

The Booklet-Certificate contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A $400 benefit reduction will be applied separately to each type of expense.

General *(GR-9N-28-01-01-OH)*

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.

Dental

East Tennessee Technology Park Health and Welfare Benefit Plan

CIGNA DENTAL PREFERRED PROVIDER INSURANCE

For East TN Technology Park

EFFECTIVE DATE: January 1, 2018

CN001

3341238

This document printed in October, 2017 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: East Tennessee Technology Park Health and Welfare Benefit Plan

GROUP POLICY(S) — COVERAGE
3341238 - DPPO1 CIGNA DENTAL PREFERRED PROVIDER INSURANCE

EFFECTIVE DATE: January 1, 2018

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Anna Krishtul
Anna Krishtul, Corporate Secretary

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Important Notices

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with Cigna, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Customer Service/Member Services at the toll-free phone number shown on your ID card, and ask an associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address: Cigna, Nondiscrimination Complaint Coordinator, P.O. Box 188016, Chattanooga, TN 37422.

If you need assistance filing a written grievance, please call the toll-free phone shown on your ID card or send an email to ACAGrievance@cigna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; or by phone at 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HC-NOT76 10-16

Proficiency of Language Assistance Services

ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1-800-244-6224 (TTY: Dial 711).

Spanish

ATENCIÓN: tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1-800-244-6224 (los usuarios de TTY deben llamar al 711).

Chinese

注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1-800-244-6224（聽障專線：請撥 711）。

Vietnamese

CHÚ Ý: Có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Dành cho khách hàng hiện tại của Cigna, gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1-800-244-6224 (TTY: Quay số 711).

Korean

주의**:** 언어 지원 서비스를 비용없이 이용하실 수 있습니다. 기존 Cigna 가입자의 경우, 가입자 ID 카드 뒷면에 있는 전화번호로 연락해 주십시오. 아니면 1-800-244-6224번으로 연락해 **주십시오**(TTY: 711번으로 전화).

Tagalog

PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1-800-244-6224 (TTY: I-dial ang 711).

Russian

ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1-800-244-6224 (TTY: 711).

Arabic

برجاء الانتباة خدمات الترجمة المجانية متاحة لكم.لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1-800-244-6224(TTY: اتصل ب 711).

French Creole

ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1-800-244-6224 (TTY: Rele 711).

French

ATTENTION: des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1-800-244-6224 (ATS: composez le numéro 711).

Portuguese

ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1-800-244-6224 (Dispositivos TTY: marque 711).

Polish

UWAGA: W celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1-800-244-6224 (TTY: wybierz 711).

Japanese

お知らせ：無料の日本語サポートサービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号におかけ下さい。その他の方は、1-800-244-6224におかけください。（文字電話: 番号711）。

Italian

ATTENZIONE: sono disponibili servizi di assistenza linguistica gratuiti. Per i clientI Cigna attuali, chiamare il numero sul retro della tessera ID. In caso contrario, chiamare il numero 1-800-244-6224 (utenti TTY: chiamare il numero 711).

German

Achtung: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Für gegenwärtige Cigna-Kunden, Bitte rufen Sie die Nummer auf der Rückseite Ihres Personalausweises. Sonst, rufen Sie 1-800-244-6224 (TTY: Wählen Sie 711).

Persian (Farsi)

توجه: خدمات کمکی زبان، رایگان در دسترس شما است. **برای مشتریان فعلی** Cigna، لطفا با شماره ای که در پشت کارت شناسایی شما است تماس بگیرید. **در غیر اینصورت، با شماره** 1-800-244-6224 **تماس بگیرید** (TTY: 711 را شماره گیری کنید).

HC-NOT77 10-16

How To File Your Claim

If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

Claim Reminders

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year of the time proof is otherwise required. Claims that are not submitted within this time period, will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

HC-CLM20 01-11

V1

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 8 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Employee Group: None.

New Employee Group: None.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

HC-ELG1 04-10
V6

Late Entrant Limit

Coverage for late entrants:

- Class I and Class II services are paid at the amounts set forth in The Schedule.
- All other classes of service are paid at 50% of the amounts set forth in The Schedule.
- After a person has been continuously insured for 12 months, this limit no longer applies.

HC-LEL1 04-10
V3

Cigna Dental Preferred Provider Insurance

The Schedule

For You and Your Dependents

The Dental Benefits Plan offered by your Employer includes Participating and non-Participating Providers. If you select a Participating Provider, your cost will be less than if you select a non-Participating Provider.

Emergency Services

The Benefit Percentage payable for Emergency Services charges made by a non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. Dental Emergency Services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee that is agreed to by the provider and Cigna. Based on the provider's Contracted Fee, a higher level of plan payment may be made to a Participating Provider resulting in a lower payment responsibility for you. To determine how your Participating Provider compares refer to your provider directory.
Provider information may change annually; refer to your provider directory prior to receiving a service. You have access to a list of all providers who participate in the network by visiting www.mycigna.com.

Non-Participating Provider Payment

Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

Simultaneous Accumulation of Amounts

Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

Expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule.

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III Combined Calendar Year Maximum	$1,500	
Class IV Lifetime Maximum	$1,500	$1,500

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Calendar Year Deductible		
Individual	$50 per person Not Applicable to Class I	
Family Maximum	$100 per family Not Applicable to Class I	
Class I		
Preventive Care	100%	100%
Class II		
Basic Restorative	80% after plan deductible	80% after plan deductible
Class III		
Major Restorative	50% after plan deductible	50% after plan deductible
Class IV		
Orthodontia	50%	50%
Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.		

Missing Teeth Limitation

The amount payable for the replacement of teeth that are missing when a person first becomes insured is 50% of the amount payable for the replacement of teeth that are extracted after a person has dental coverage.

This payment limitation no longer applies after 12 months of continuous coverage.

This limit will not apply to any person who is a member of the Initial Employee group.

HC-MTL7 04-10
V1

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $200.

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Covered Services

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

HC-DEN1 04-10
V1

Dental PPO – Participating and Non-Participating Providers

Plan payment for a covered service delivered by a Participating Provider is the Contracted Fee for that procedure, times the benefit percentage that applies to the class of service, as specified in The Schedule.

The covered person is responsible for the balance of the Contracted Fee.

Plan payment for a covered service delivered by a non-Participating Provider is the Maximum Reimbursable Charge for that procedure, times the benefit percentage that applies to the class of service, as specified in The Schedule.

The covered person is responsible for the balance of the non-Participating Provider's actual charge.

HC-DEN171 07-14
V1

Class I Services – Diagnostic and Preventive

Clinical oral examination – Only 2 per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

Bitewing x-rays – Only 2 charges per person per calendar year.

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only 1 treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

HC-DEN3 04-10
V5

Class II Services – Basic Restorations, Periodontics, Endodontics, Oral Surgery, Prosthodontic Maintenance

Amalgam Filling

Composite/Resin Filling

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months.

HC-DEN163 04-10
V3

Class III Services - Major Restorations, Dentures and Bridgework

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.

General Anesthesia – Paid as a separate benefit only when medically or dentally necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I.V. Sedation – Paid as a separate benefit only when medically or dentally necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

HC-DEN172 07-14
V1M

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the dentist, up to four times per calendar year.

The total amount payable for all expenses incurred for orthodontics during a Dependent child's lifetime will not be more than the orthodontia maximum shown in the Schedule.

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while such child is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

HC-DEN6 04-10
V3

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;
- services for which benefits are not payable according to the “General Limitations” section.

HC-DEX1 04-10
V1M

General Limitations

Dental Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;

- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

HC-DEX1 04-10
V3M

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical or dental care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area

where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection

with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

HC-COB6 04-10
V1

Expenses for Which a Third Party May Be Responsible

Cigna shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party for dental expenses and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid for such expenses under the Policy. Cigna's right of subrogation is second to your right to be fully compensated for damages. You or your representative shall execute such documents as may be required to secure Cigna's subrogation rights.

To the extent that benefits are provided or paid under this Policy, you agree that if you fully recover damages from a third party, you will refund to Cigna the amount actually paid for such Covered Expenses by Cigna less any amount required to cover damages in full, from the amount you actually received from the third party for such Covered Expenses at the time that the third party's liability is determined and satisfied, whether by settlement, judgment arbitration or award or otherwise.

HC-SUB32 04-10
V1

Payment of Benefits

To Whom Payable

Dental Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. Recovery of overpayment is limited to 18 months from the date the claim was paid. However, this 18 month time limit will not apply if the insured does not provide complete information, was not eligible for coverage or if material misstatements or fraud have occurred.

HC-POB41 04-10
V1

Miscellaneous

As a Cigna Dental plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at www.cigna.com for details.

If you are a Cigna Dental plan member you may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

HC-POB5 04-10
V1

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Injury or Sickness

If your Active Service ends due to an injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the injury or Sickness. However, your insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels your insurance.

Retirement

If your Active Service ends because you retire, and you are under age 65, your insurance will be continued until the earlier of: a) the date on which your Employer stops paying premium for you or otherwise cancels the insurance; or b) your 65th birthday.

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM3 04-10
V1M

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

HC-BEX3 04-10
V1

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of dental practitioners, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4 10-10

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 31 days of the following:

- the date you meet the criteria shown in the following Sections B through H.

B. Change of Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

HC-FED91 04-17

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67 09-14

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13 10-10

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave

Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

HC-FED17 10-10

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18M 10-10

Claim Determination Procedures under ERISA

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be medically necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

You or your authorized representative (typically, your health care professional) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: the specific reason or reasons for the adverse determination; reference to

the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED83M 03-13

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA

continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your

covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED66 07-14

ERISA Required Information

The name of the Plan is:

East Tennessee Technology Park Health and Welfare Benefit Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

URS CH2M Oak Ridge LLC
P.O. Box 4699
Oak Ridge, TN 37831
865-576-8871

Employer Identification Number (EIN):	Plan Number:
452178216	510

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;

- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FED72M 05-15

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

HC-SPP4 04-10
V1

The Following Will Apply To Residents of Tennessee

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

> Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To start a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Dentist reviewer. You may present your situation to the Committee in person or by conference call.

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

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

> Tennessee Department of Commerce and Insurance
> 500 James Robertson Parkway
> Nashville, TN 37423
> 800-342-4029

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding

your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

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

Legal Action

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

HC-APL41 04-10
V1

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1 04-10
V1

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

HC-DFS122 04-10
V1

Contracted Fee

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

HC-DFS123 04-10
V1

Dentist

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

HC-DFS125 04-10
V3

Dependent

Dependents are:

- your lawful spouse; and
- any child of yours who is:
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you, including that child from the first day of placement in your home regardless of whether the adoption has become final. It also includes a stepchild or a child for whom you are the legal guardian.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

HC-DFS201 04-10
V2

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 8 hours a week for the Employer.

HC-DFS7 04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Maximum Reimbursable Charge - Dental

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS752 07-14
V5

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HC-DFS16 04-10
V1

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

HC-DFS17 04-10
V1

Participating Provider

The term Participating Provider means: a dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with Cigna to provide dental services at predetermined fees.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by your Employer.

HC-DFS136 04-10
V1

Vision

Group Vision Care Plan

Vision Care for Life

Group Name: **URS CH2M OAK RIDGE LLC**
Group Number: **12090444**
Effective Date: **JANUARY 1, 2018**

EVIDENCE OF COVERAGE

Provided by:

VISION SERVICE PLAN INSURANCE COMPANY
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

To be filled in by employer in the event this document is used to develop a Summary Plan Description:

NAME OF EMPLOYER: Employers Participating in the East Tennessee Technology Park Health and Welfare Benefit Plan
NAME OF PLAN: East Tennessee Technology Park Health and Welfare Benefit Plan
PRINCIPAL ADDRESS: P.O. Box 4699, K-1007, MS 7020, Oak Ridge, TN 37831

EMPLOYER I.D.#: 45-2178216

GROUP #:12090444

PLAN ADMINISTRATOR: c/o URS | CH2M Oak Ridge LLC (UCOR)
ADDRESS: P.O. Box 4699, K-1007, MS 7020, Oak Ridge, TN 37831

PHONE NUMBER: 865-576-8871

REGISTERED AGENT FOR SERVICE OF LEGAL PROCESS, IF DIFFERENT FROM PLAN ADMINISTRATOR:

CT Corporation Systems

ADDRESS: 800 South Gay Street, Suite 2021, Knoxville, TN 37929

Benefits are furnished under a vision care Policy purchased by the Group and provided by VISION SERVICE PLAN INSURANCE COMPANY (VSP) under which VSP is financially responsible for the payment of claims.

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. In the event of any dispute between this Evidence of Coverage and the Policy, the provisions of the Policy will prevail. A copy of the Policy will be furnished on request.

DEFINITIONS:

ADDITIONAL BENEFITS RIDER The document attached as Exhibit C to the Group Policy maintained by your Group Administrator, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.

BENEFIT AUTHORIZATION Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.

COORDINATION OF BENEFITS Procedure that allows more than one insurance plan to consider Covered Person's vision care claims for payment or reimbursement.

COPAYMENTS Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials provided.

COVERED PERSON An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Policy.

ELIGIBLE DEPENDENT Any legal dependent of an Enrollee of Group who meets the eligibility criteria established by Group and approved by VSP under Section VI. ELIGIBILITY FOR COVERAGE of the Policy under which such Enrollee is covered.

EMERGENCY CONDITION A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.

ENROLLEE An employee or member of the Group who meets the eligibility criteria specified under Section VI. ELIGIBILITY FOR COVERAGE of the Policy.

EXPERIMENTAL NATURE A procedure or lens that is neither used universally nor accepted by the vision care profession, as determined by VSP.

GROUP An employer or other entity that contracts with VSP for coverage under this Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

VSP NETWORK DOCTOR An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.

NON-VSP PROVIDER An optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

PLAN or PLAN BENEFITS The vision care services and vision care materials that a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).

POLICY The contract between VSP and Group upon which this Plan is based.

PREMIUMS The Payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Policy document maintained by your Group Administrator.

RENEWAL DATE The date on which the Policy shall renew or terminate if proper notice is given.

SCHEDULE OF BENEFITS The document attached as Exhibit A to the Group Policy maintained by your Group Administrator, that lists the vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.

SCHEDULE OF PREMIUMS The document attached as Exhibit B to the Group Policy maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

ELIGIBILITY FOR COVERAGE

Enrollees: To be covered, a person must currently be an employee or member of the Group and meet the established coverage criteria mutually agreed upon by Group and VSP.

Eligible Dependents: If dependent coverage is provided, the persons eligible are indicated on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).

PREMIUMS

Group is responsible for payments of the periodic charges for coverage. Group will notify Covered Person of Covered Person's share of the charges, if any. The entire cost of the program is paid to VSP by Group.

PROCEDURE FOR USING THE PLAN

1. When Covered Person wants to receive Plan Benefits, contact VSP or a VSP Network Doctor. A list of names, addresses and phone numbers of VSP Network Doctors in Covered Person's area can be obtained from Group, the Plan Administrator or VSP. If this list does not cover the area in which Covered Person desires to seek services, call or write the VSP office nearest Covered Person to find one that does.

2. If Covered Person is eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the VSP Network Doctor. If Covered Person contacts the VSP Network Doctor directly, Covered Person must identify him or herself as a VSP member so the doctor can obtain Benefit Authorization from VSP.

3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Policy, in spite of Covered Person's termination of coverage or the termination of the Policy Should Covered Person receive services from a VSP Network Doctor without such Benefit Authorization or obtain services from a Non-VSP Provider, Covered Person is responsible for payment in full to the provider.

4. Covered Person pays the Copayment (if any) amounts that exceed the Plan Allowances and any amounts for non-covered services or materials to the VSP Network Doctor for services under this Policy. VSP will pay the VSP Network Doctor directly according to its agreement with the doctor.

   Note: If Covered Person is eligible for and obtains Plan Benefits from an Non-VSP Provider, Covered Person should pay the provider's full fee. Covered Person will be reimbursed by VSP in accordance with the Non-VSP Provider reimbursement schedule shown on the enclosed Schedule of Benefits and Additional Benefit Rider (if applicable), less any applicable Copayments.

   WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-VSP PROVIDERS ARE USED.

   Covered Persons should be aware that when they elect to utilize the services of an Non-VSP Provider for a covered service in non-emergency situations, benefit payments for services from such Non-VSP Providers are not based upon the amount billed. The basis of the benefit payment will be determined according to the Plan's Non-VSP Provider fee schedule.

   COVERED PERSONS CAN EXPECT TO BE LIABLE FOR MORE THAN THE COPAYMENT AMOUNT DEFINED IN THE ATTACHED SCHEDULE OF BENEFITS OR ADDITIONAL BENEFIT RIDER (if applicable) AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.

   When payment is made to the Non-VSP Provider, the provider may bill Covered Person for any amount up to the billed charge after the Plan has paid its portion of the bill. VSP Network Doctors have agreed to accept discounted payments for services with no additional billing to the Covered Person other than copayments, co-insurance and non-covered services or materials. Covered Persons may obtain further information about the participating status of providers and information on out-of-pocket expenses through vsp.com, or by calling VSP's Customer Service Department at 1-800-877-7195.

5. In emergency conditions, when immediate vision care of a medical nature, such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a VSP Network Doctor (or Non-VSP Provider if the attached Schedule of Benefits and, if applicable, Additional Benefits Rider, indicates Covered Person's Plan includes such coverage). No prior authorization from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Supplemental Primary EyeCare Plans. If there is no Additional Benefit Rider for one of these plans attached to this Evidence of Coverage, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care.

   For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance. Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to VSP Network Doctors will be made in accordance with their agreement with VSP.

6. In the event of termination of a VSP Network Doctor's membership in VSP, VSP will be liable to the VSP Network Doctor for services rendered to Covered Person at the time of termination and permit the VSP Network Doctor to continue to provide Covered Person with Plan Benefits until the services are completed, or until VSP makes reasonable and appropriate arrangements for the provision of such services by another VSP Network Doctor.

BENEFIT AUTHORIZATION PROCESS

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Covered Person by Group under this Plan. When Covered Person requests services under this Plan, Covered Person's prior utilization of Plan Benefits will be reviewed by VSP to determine if Covered Person is eligible for new services based upon Covered Person's Plan's level of coverage. Please refer to the attached Schedule of Benefits and Additional Benefit Rider (if applicable) for a summary of the level of coverage provided to Covered Person by Group.

BENEFITS AND COVERAGES
Through its VSP Network Doctors, VSP provides Plan Benefits to Covered Persons, subject to the limitations, exclusions and Copayment(s) described herein. When Covered Person wishes to obtain Plan Benefits from a VSP Network Doctor, Covered Person may contact any VSP Network Doctor, identify Covered Person as a VSP member and schedule an appointment. If Covered Person is eligible for Plan Benefits, VSP will provide Benefit Authorization for Covered Person directly to the VSP Network Doctor prior to Covered Person's appointment.

Specific benefits for which Covered Person is covered are described on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).

COPAYMENT
The benefits described herein are available to Covered Person subject to Covered Person's payment of any applicable Copayments as described in this Evidence of Coverage, the Schedule of Benefits and Additional Benefit Riders (if applicable). Amounts that exceed plan allowances, annual maximum benefits, options reimbursements, or any other stated Plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN COVERED PERSON AND THE DOCTOR.

COORDINATION OF BENEFITS
Covered Persons who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under Covered Person's VSP plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

EXCLUSIONS AND LIMITATIONS OF BENEFITS
This vision service plan is designed to cover *visual needs* rather than *cosmetic materials.* Some professional services and/or materials are not covered under this Plan. Please refer to the NOT COVERED section of the attached Schedule of Benefits and Additional Benefit Rider (if applicable) for details.

VSP may, at its discretion, waive any of the Plan limitations if, in the opinion of our Optometric Consultants, this is necessary for the visual welfare of the Covered Person.

LIABILITY IN EVENT OF NON-PAYMENT
IN THE EVENT VSP FAILS TO PAY THE PROVIDER, COVERED PERSON SHALL NOT BE HELD LIABLE FOR ANY SUMS OWED BY VSP OTHER THAN THOSE NOT COVERED BY THE PLAN.

COMPLAINTS AND GRIEVANCES:
If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

CLAIM PAYMENTS AND DENIALS
Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Request for Appeals: If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the

Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed.

VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person's authorized representative should submit all requests for appeals to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

VSP's final review determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U. S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

TERMINATION OF BENEFITS
After the Policy Term, this Policy will continue on a month to month basis or until terminated by either party giving the other party sixty (60) days notice. Policy Benefits will cease on the date of cancellation of this Policy whether the cancellation is by your Group or by VSP due to nonpayment of Premium.

If Covered Person is receiving service as of the termination date of the Policy, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the Policy.

INDIVIDUAL CONTINUATION OF BENEFITS
This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

EXHIBIT A

SCHEDULE OF BENEFITS
SIGNATURE PLAN

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-VSP Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether VSP Network Doctors or Non-VSP Providers . This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

When Plan Benefits are received from VSP Network Doctors, benefits appearing in the VSP Network Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are received from Non-VSP Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-VSP Provider Benefit column below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-VSP Providers.

ELIGIBILITY

The following are Covered Persons under this Policy:

- Enrollee.
- The legal spouse of Enrollee.
- Any child of Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from VSP Network Doctors and Non-VSP Providers require Copayments. Covered Persons must also follow Benefit Authorization Procedures.

There shall be no Copayment payable by the Covered Person to the VSP Network Doctor or the Non-VSP Provider at the time services are rendered.

PLAN BENEFITS

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $ 50.00*	Available once each 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first date of service.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each 12 months**
Single Vision	Covered in full *	Up to $ 50.00*	
Bifocal	Covered in full *	Up to $ 75.00*	
Trifocal	Covered in full *	Up to $ 100.00*	
Lenticular	Covered in full *	Up to $ 125.00*	
Plan Benefits for lenses are per complete set, not per lens. *Less any applicable Copayment. **Beginning with the first date of service.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LENS OPTIONS			Available once each 12 months**
Polycarbonate Lenses	Covered in full	Not Covered	
** Beginning with the first date of service.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to $ 70.00*	Available once each 24 months**
Benefits for lenses and frames include reimbursement for the following necessary professional services: 1. Prescribing and ordering proper lenses; 2. Assisting in frame selection; 3. Verifying accuracy of finished lenses; 4. Proper fitting and adjustments of frames; 5. Subsequent adjustments to frames to maintain comfort and efficiency; 6. Progress or follow-up work as necessary. *Less any applicable Copayment. **Beginning with the first date of service. Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary			Available once each 12 months**
Professional Fees/Materials	Covered in full*	Up to $ 210.00*	
Elective	Elective Contact Lens fitting and evaluation*** services are covered in full once every 12 months**, after a maximum $60.00 Copayment.		Available once each 12 months**
	Materials Up to $ 120.00	**Professional Fees/Materials** Up to $ 105.00	

*Less any applicable Copayment.
**Beginning with the first date of service.
***15% Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Doctor or Non-VSP Provider. Review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.
When contact lenses are obtained, the Covered Person shall not be eligible for lenses again for 12 months and frames for 24 months.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LOW VISION			
Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing	Covered in full (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	Up to $125.00	*
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years.

Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a ± .50 diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above Plan Benefit allowances.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and Materials who are not contracted as VSP Network Doctors but who have agreed to bill VSP directly for Plan Benefits provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Plan Benefits included in this Schedule. Covered Persons should discuss requested services with their provider or contact VSP Customer Care for details.

COPAYMENT

There shall be no Copayment payable by the Covered Person under this Plan.

COVERED SERVICES AND MATERIALS

Eye Examination	Covered in full *	Available once each 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Spectacle Lenses		
Single Vision, Lined Bifocal or Lined Trifocal,	Covered in Full*	Available once each 12 months**

LENS OPTIONS
Polycarbonate Lenses-Covered in full once every 12 months**

Frames	Covered up to the Plan allowance*	Available once each 24 months**

CONTACT LENSES

Elective Contact Lenses (Materials Only)	Up to $ 120.00	Available once each 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $60.00 Copayment.

Necessary Contact Lenses	Up to $210.00*	Available once each 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**Beginning with the first date of service.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to $ 125.00†
-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Affiliate Provider's fee up to $1000.00†

†Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for VSP Network Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a VSP Network Doctor or a Non-VSP Provider.
3. VSP is unable to require Affiliate Providers to adhere to VSP's quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.

ADDENDUM

VISION SERVICE PLAN INSURANCE COMPANY
ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the Policy or Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Policy, pursuant to eligibility criteria established by Client:

- Enrollee.
- The legal spouse of Enrollee.
- Any child of Enrollee, including any natural child from the date of birth, adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

PROGRAM DESCRIPTION

The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to Covered Person's group medical plan. Providers will first submit a claim to Covered Person's group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in an Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- "floating" spots

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- rubeosis

REFERRALS

If Covered Person's Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Insured to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Person do not require a referral from a Member Doctor in order to obtain Plan Benefits.**

PLAN BENEFITS
VSP NETWORK DOCTORS

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of $20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Person upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as Plan Benefits.
2. Frames, lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where the Company is required by law to pay.

DIABETIC EYECARE PROGRAM DEFINITIONS

Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.

PLAN BENEFITS
NON-MEMBER PROVIDERS

1. A Non-Member Provider may require Covered Person to pay for all services in full at the time of the visit. If so, Covered Person should then submit a claim to the Company for reimbursement.

COVERED SERVICES

Eye Examination: Covered up to $ 100.00 after a $20.00 Copayment.

Special Ophthalmological Services: Covered up to $120.00 per individual service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Non-Member Providers.
2. Services from a Non-Member Provider are in lieu of services from a Member Doctor.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. The Company is unable to require Non-Member Providers to adhere to the Company's quality standards.

Summary of Benefits and Coverage
SIGNATURE PLAN

Prepared for: URS CH2M OAK RIDGE LLC
Group ID: 12090444
Effective Date: JANUARY 1, 2018

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations and Exceptions
If you or your dependents (if applicable) need eyecare	Eye Exam	$0.00 Copay	Reimbursed up to $50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: $0.00 Copay (lenses and/or frames only); Up to $60.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 50.00 Bi-Focal Lenses reimbursed up to $ 75.00 Tri-Focal Lenses reimbursed up to $100.00 Lenticular Lenses reimbursed up to $125.00 ECL reimbursed up to $105.00	Frames covered every 24 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first date of service.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

LTD

GROUP INSURANCE POLICY
NON-PARTICIPATING

POLICYHOLDER: URS / CH2M Oak Ridge LLC (UCOR)

POLICY NUMBER: 617354 001

POLICY EFFECTIVE DATE: January 1, 2018

POLICY ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: Tennessee

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this policy. Unum makes this promise subject to all of this policy's provisions.

The policyholder should read this policy carefully and contact Unum promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. This policy consists of:

- all policy provisions and any amendments and/or attachments issued;
- employees' signed applications; and
- the certificate of coverage.

This policy may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for Unum at Portland, Maine on the Policy Effective Date.

President

Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

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BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began and the monthly benefit option that you chose. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2018

PLAN YEAR:

January 1, 2018 to December 31, 2018 and each following January 1 to December 31

POLICY NUMBER: 617354 001

ELIGIBLE GROUP(S):

Group 1
Salaried Employees eligible for participation in the LTD plan under The East Tennessee Technology Park Health & Welfare Benefit Plan, except for employees at Portsmouth Mission Alliance, LLC (PMA) and Fluor-BWXT Portsmouth LLC (FBW).

Group 2
Bargaining Unit Employees eligible to participate in The East Tennessee Technology Park Health and Welfare Benefit Plan in active employment in the United States

MINIMUM HOURS REQUIREMENT:

Employees must be working full-time as defined by the Employer.

WAITING PERIOD:

For employees in an eligible group on or before January 1, 2018: None

For employees entering an eligible group after January 1, 2018: None

WHO PAYS FOR THE COVERAGE:

Salaried Employees eligible for participation in the LTD plan
Option A (40% Benefit)

Your Employer pays the cost of your coverage.

Option B (Employee Elective 20% Buy-up)

You and your Employer share the cost of your coverage.

Bargaining Unit Employees eligible to participate in The East Tennessee Technology Park Health and Welfare Benefit Plan
Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

180 days

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

Salaried Employees eligible for participation in the LTD plan

Option A

40% of monthly earnings to a maximum benefit of $6,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

Option B (Employee Elective Buy-up)

60% of monthly earnings to a maximum benefit of $6,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

Bargaining Unit Employees eligible to participate in The East Tennessee Technology Park Health and Welfare Benefit Plan

60% of monthly earnings to a maximum benefit of $6,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

Age at Disability	Maximum Period of Payment
Less than age 60	To age 65, but not less than 5 years
Age 60 through 64	5 years
Age 65 through 69	To age 70, but not less than 1 year
Age 70 and over	1 year

No premium payments are required for your coverage while you are receiving payments under this plan.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

DEPENDENT CARE EXPENSE BENEFIT:

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $350 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

TOTAL BENEFIT CAP:

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

OTHER FEATURES:

Continuity of Coverage

Minimum Benefit

Pre-Existing: 3/12

Survivor Benefit

Work Life Assistance Program

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

LONG TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send Unum written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

The claim form is available from the Benefits Administrator, or you can request a claim form from us. If you do not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE A CLAIM?

You and the Benefits Administrator must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the appropriate documentation of your monthly earnings;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

POLICYHOLDER PROVISIONS

WHAT IS THE COST OF THIS INSURANCE?

LONG TERM DISABILITY

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

WAIVER OF PREMIUM

Unum does not require premium payments for an insured while he or she is receiving Long Term Disability payments under this plan.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS POLICY?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The **Policyholder** must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases, for other than salary changes, which take effect during a plan month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

Premium increases or decreases due to salary changes should be adjusted on the next premium due date.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current plan year and the prior plan year. In the case of fraud, premium adjustments will be made for all plan years.

WHAT INFORMATION DOES UNUM REQUIRE FROM THE POLICYHOLDER?

The Policyholder must provide Unum with the following on a regular basis:

- information about employees:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee's coverage to begin or continue when the coverage would not otherwise be effective.

WHO CAN CANCEL OR MODIFY THIS POLICY OR A PLAN UNDER THIS POLICY?

This policy or a plan under this policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify this policy or a plan if:

- there is less than 25% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for a Policyholder paid plan;
- the Policyholder refuses to provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to this policy;
- fewer than 25 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the employee, or both, pay(s) the premiums;
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder and/or its employees; or
- the Policyholder fails to pay any portion of the premium within the 45 day **grace period**.

If Unum cancels or modifies this policy or a plan for reasons other than the Policyholder's failure to pay premium, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date and the Policyholder will be given an opportunity to cure and avoid cancellation. The Policyholder may cancel this policy or a plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum may cancel at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay Unum all premium due for the full period each plan is in force.

The Policyholder may cancel this policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, this policy or a plan can be cancelled on an earlier date. If Unum or the Policyholder cancels this policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this policy or a plan is cancelled, the cancellation will not affect a **payable claim**.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS POLICY WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue the employee's coverage in accordance with the policyholder's Human Resource policy on family and medical leaves of absence if premium payments continue and the policyholder approved the employee's leave in writing.

Coverage will be continued until the end of the later of:

1. the leave period required by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period required by applicable state law.

If the policyholder's Human Resource policy doesn't provide for continuation of an employee's coverage during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period;
- apply a new pre-existing conditions exclusion; or
- require evidence of insurability.

PARTICIPATING COMPANIES INCLUDE:

NAME/LOCATION (CITY AND STATE)

Certain Department of Energy Contractors and Subcontractors who have adopted certain ETTP Health and Welfare Benefit Plans as set forth in the executed Adoption Agreements.

CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

Salaried Employees eligible for participation in the LTD plan
This plan provides different benefit options. When you first become eligible for coverage, you may apply for any option, however, you cannot be covered under more than one option at a time.

Your Employer pays 100% of the cost of your coverage for Option A. If you don't apply for any other option you will automatically be covered under Option A at 12:01 a.m. on the date you are eligible for coverage.

You and your Employer share the cost of your coverage for any other option. You will be covered at 12:01 a.m. on the date you are eligible for coverage, if you apply for insurance on or before that date.

If you first become eligible for coverage after the plan effective date, you will be covered at 12:01 a.m. on the later of:

- the date you are eligible for coverage, if you apply for insurance on or before that date; or
- the date you apply for insurance, if you apply within 31 days after your eligibility date.

Bargaining Unit Employees eligible to participate in The East Tennessee Technology Park Health and Welfare Benefit Plan
When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the date you are eligible for coverage.

WHEN CAN YOU CHANGE YOUR COVERAGE BY CHOOSING ANOTHER OPTION?

Salaried Employees eligible for participation in the LTD plan
You can change your coverage by applying for a different option only during an **annual enrollment period** or within 31 days of a **change in status**. You can increase your coverage to Option B or decrease your coverage to Option A.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in coverage that is made during an annual enrollment period will begin at 12:01 a.m. on the first day of the next plan year.

A change in coverage due to a change in status will begin at 12:01 a.m. on the later of:

- the date of the change in status, if you apply on or before that date; or
- the date you apply, if you apply within 31 days after the date of the change in status.

Changes in coverage must be consistent with the change in employment status.

If you end employment and are rehired within the same plan year, you may be insured on your eligibility date for the coverage that you had under the plan when you ended employment. You cannot change your coverage until the next annual enrollment period or change in employment status.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary **layoff**, and if premium is paid, you will be covered for up to 3 months following the date your temporary layoff begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 3 months following the date your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your monthly earnings or due to a plan change requested by your Employer will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LONG TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**. Unum will treat your disability as continuous if your disability stops for 30 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period is 180 days.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If you are working while you are disabled, the days you are disabled will count toward your elimination period.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment monthly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

Salaried Employees eligible for participation in the LTD plan
OPTION A

1. Multiply your monthly earnings by 40%.
2. The maximum **monthly benefit** is $6,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

OPTION B

1. Multiply your monthly earnings by 60%.
2. The maximum **monthly benefit** is $6,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

Bargaining Unit Employees eligible to participate in The East Tennessee Technology Park Health and *Welfare Benefit Plan*
1. Multiply your monthly earnings by 60%.
2. The maximum **monthly benefit** is $6,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY EARNINGS?

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

WHAT ARE YOUR MONTHLY EARNINGS?

"Monthly Earnings" means your gross monthly income from your Employer, not including shift differential, in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR MONTHLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the monthly payment if you are disabled and your monthly **disability earnings**, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, due to the same sickness or injury, Unum will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Unum will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Unum will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2.

This is the amount Unum will pay you each month.

Unum may require you to send proof of your monthly disability earnings at least quarterly. We will adjust your payment based on your quarterly disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records which we believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your payment for each day of disability.

HOW CAN WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings routinely fluctuate widely from month to month, Unum may average your disability earnings over the most recent 3 months to determine if your claim should continue.

If Unum averages your disability earnings, we will not terminate your claim unless the average of your disability earnings from the last 3 months exceeds 80% of indexed monthly earnings.

We will not pay you for any month during which disability earnings exceed 80% of indexed monthly earnings.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:

   - a workers' compensation law.
   - an occupational disease law.
   - any other **act** or **law** with similar intent.

2. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:

   - state compulsory benefit **act** or **law**.
   - group plan sponsored by your Employer.
   - other group insurance plan.
   - **governmental retirement system**.

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:

   - the United States Social Security Act.
   - the Canada Pension **Plan**.
   - the Quebec Pension Plan.
   - any similar plan or act.

4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:

   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

5. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount that you:

   - receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

   Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

7. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities

- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- no fault motor vehicle plans
- **salary continuation** or **accumulated sick leave** plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum monthly payment is the greater of:

- $100; or
- 10% of your gross disability payment.

Unum may apply this amount toward an outstanding overpayment.

WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?

Once Unum has subtracted any deductible source of income from your gross disability payment, Unum will not further reduce your payment due to a cost of living increase from that source.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1, 2 and 3 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Long Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1, 2 and 3 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or

- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each month up to the **maximum period of payment**. Your maximum period of payment is based on your age at disability as follows:

Age at Disability	Maximum Period of Payment
Less than age 60	To age 65, but not less than 5 years
Age 60 through 64	5 years
Age 65 through 69	To age 70, but not less than 1 year
Age 70 and over	1 year

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a **part-time basis** but you do not;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

WHAT DISABILITIES HAVE A LIMITED PAY PERIOD UNDER YOUR PLAN?

The lifetime cumulative maximum benefit period for all disabilities due to **mental illness** and disabilities based primarily on **self-reported symptoms** is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

- are not continuous; and/or
- are not related.

Unum will continue to send you payments beyond the 24 month period if you meet one or both of these conditions:

1. If you are confined to a **hospital or institution** at the end of the 24 month period, Unum will continue to send you payments during your confinement.

   If you are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days.

   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if, after the 24 month period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, Unum will send payments during the length of the reconfinement.

Unum will not pay beyond the limited pay period as indicated above, or the maximum period of payment, whichever occurs first.

Unum will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT IS A PRE-EXISTING CONDITION?

You have a pre-existing condition when you apply for coverage when you first become eligible if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and

- the disability begins in the first 12 months after your effective date of coverage.

In addition, this plan will not cover an increase in your coverage made at an annual enrollment period or change in status if you have a pre-existing condition. You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to the date your coverage increased; and
- the disability begins in the first 12 months after your coverage increased.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME WITH THE POLICYHOLDER AND YOUR DISABILITY OCCURS AGAIN?

If you have a **recurrent disability**, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

If you become entitled to payments under any other group long term disability plan, you will not be eligible for payments under the Unum plan.

LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that you have died, we will pay your **eligible survivor** a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 3 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 3 months of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 3 month survivor benefit will be payable upon your death.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

When the plan becomes effective, Unum will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which your prior carrier is liable.

WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained inforce; or
b. the monthly payment under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the Total Benefit Cap will apply.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which monthly payments would stop in accordance with this plan.

WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:

1. are incurring expenses to provide care for a child under the age of 15; and/or
2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start Unum's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent Care Expense Benefit will:

1. be $350 per month, per **dependent**; and
2. not exceed $1,000 per month for all dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

1. the date you are no longer incurring expenses for your dependent;
2. the date you no longer participate in Unum's Rehabilitation and Return to Work Assistance program; or
3. any other date payments would stop in accordance with this plan.

OTHER SERVICES

These services are also available from us as part of your Unum Long Term Disability plan.

IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE PLAN?

We do provide you and your dependents access to a work life assistance program designed to assist you with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your Employer.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Unum.

When this occurs, Unum will reimburse your Employer for the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

HOW CAN UNUM'S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?

In order to be eligible for assistance from Unum's Social Security claimant advocacy program, you must be receiving monthly payments from us. Unum can provide expert advice regarding your claim and assist you with your application or appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.

GLOSSARY

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

ANNUAL ENROLLMENT PERIOD means a period of time before the beginning of each plan year.

CHANGE IN STATUS means a change in status as defined in the regulations under Internal Revenue Code section 125, unless your Employer's cafeteria plan document or human resource policy contains more restrictive provisions. In that event, your Employer may restrict the situations where you can change your coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DEPENDENT means:

- your child(ren) under the age of 15; and
- your child(ren) age 15 or over or a family member who requires personal care assistance.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your **maximum capacity**.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

80% of your indexed monthly earnings, if you are working; or
60% of your indexed monthly earnings, if you are not working.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INDEXED MONTHLY EARNINGS means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working and in the determination of gainful occupation.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

MAXIMUM CAPACITY means, based on your restrictions and limitations:

- during the first 24 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

- beyond 24 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

MAXIMUM PERIOD OF PAYMENT means the longest period of time Unum will make payments to you for any one period of disability.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders relatable to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

MONTHLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

MONTHLY EARNINGS means your gross monthly income from your Employer as defined in the plan.

MONTHLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your indexed monthly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

POLICYHOLDER means the Employer to whom the policy is issued.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

RECURRENT DISABILITY means a disability which is:

- caused by a worsening in your condition; and

- due to the same cause(s) as your prior disability for which Unum made a Long Term Disability payment.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your monthly payment.

SELF-REPORTED SYMPTOMS means the manifestations of your condition which you tell your physician, that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

SURVIVOR, ELIGIBLE means your spouse, if living; otherwise your children under age 25 equally.

TOTAL COVERED PAYROLL means the total amount of monthly earnings for which employees are insured under this plan.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

YOU means an employee who is eligible for Unum coverage.

LONG TERM DISABILITY/SHORT TERM DISABILITY

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.

State variations apply and are subject to change. Consult your employer or plan administrator for the most current state provisions that may apply to you.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia.
Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

The states of **Florida and Maryland** require us to advise residents of those states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

For residents of Colorado:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The **WHAT *DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **BENEFIT INFORMATION** section of the policy and in the **SPOUSE DISABILITY BENEFIT** provision in the **OTHER BENEFIT FEATURES** section of the policy is amended to provide that any exclusion for disabilities caused by, contributed to by, or resulting from your intentionally self-inflicted injuries will be applied only if you were sane when the injury was inflicted.

For residents of Louisiana:

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 3 years.

For residents of Minnesota:

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

The ***WHAT ARE DEDUCTIBLE SOURCES OF INCOME?*** provision in the **BENEFIT INFORMATION** section of the policy is amended so that deductible sources of income will not include any amounts you receive as mandatory portions of any "no fault" motor vehicle plan or any amounts received from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, until after you have been fully compensated from this other source.

The **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy will be applied by deleting the phrase "or you had symptoms for which an ordinarily prudent person would have consulted a health care provider."

If your coverage includes the **Spouse Disability Rider** benefit the exclusions for mental illness and alcoholism applicable to the rider are removed.

For residents of Montana:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The definition of pre-existing condition found in the provisions ***WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*** and ***WHAT DISABILITIES ARE NOT COVERED FOR A COST OF LIVING INCREASE?*** in the **BENEFIT INFORMATION** section of the policy, is amended to limit a pre-existing condition to "a sickness or injury for which you received medical advice or treatment from a provider of health care services or medical advice or treatment was recommended by a provider of health care services" during the time period specified in the policy.

For residents of New Hampshire:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

For residents of North Carolina:

The definition of pre-existing condition found in the provisions ***WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*** and ***WHAT DISABILITIES ARE NOT COVERED FOR A COST OF LIVING INCREASE?*** in the **BENEFIT INFORMATION** section of the policy, is amended by removing any reference to "symptoms arising from the sickness or injury, whether diagnosed or not."

For residents of South Carolina:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The ***WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM?*** provision in the **BENEFIT INFORMATION** section of the policy, is amended to provide that Unum will credit the pre-existing condition period you satisfied under another similar group disability policy if you were covered under the prior policy within 30 days of being effective under this policy and you applied for this coverage when you first became eligible.

For residents of South Dakota:

The **Pre-existing Condition** limitation in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** limitation in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of Texas:

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

The **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy will be applied by deleting the phrase "or you had symptoms for which an ordinarily prudent person would have consulted a health care provider."

For residents of Utah:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it

will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

For residents of Vermont:

If the policy is marketed in Vermont, the policyholder has a principal office or is organized in Vermont, or there are more than 25 Vermont residents insured under the policy:

The limitation specifying the number of months payments will be made for a disability caused by a mental and nervous condition is removed.

The **MINIMUM HOURS REQUIREMENT** stated in the **BENEFITS AT A GLANCE** section of the policy is reduced to 17.5 hours per week.

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of West Virginia:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of Wisconsin:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

Additional Claim and Appeal Information
Relative to policy issued by Unum Life Insurance Company of America ("Unum")

APPLICABILITY OF ERISA

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the policy, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator and the formal plan document. Benefit determinations are controlled exclusively by the policy, your certificate of coverage, and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

Our Commitment to Privacy

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

COVERAGE DECISIONS

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

SAFEGUARDING INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, C476, Portland, Maine 04122.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company and The Paul Revere Life Insurance Company.

MK-1883 (09/15)

NOTICE CONCERNING COVERAGE UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association**.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;

- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010.

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
    - $100,000 for limited benefits and supplemental health coverages
    - $300,000 for disability and long term care insurance
    - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

****

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is **NOT** provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Tennessee Life and Health Insurance Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, Tennessee 37219

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, Tennessee 37243

Life

Employee Group Term Life Certificate of Insurance

Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

Effective January 1, 2018

URS CH2M Oak Ridge LLC (UCOR)
Salaried Fluor-BWXT Portsmouth LLC (FBWXT)
Salaried Portsmouth Mission Alliance LLC (PMA)
Four Rivers Nuclear Partnership, LLC (FRNP) and
Wastren Advantage Inc. (WAI)

POLICYHOLDER: URS | CH2M Oak Ridge LLC (UCOR) Plan Sponsor of the East Tennessee Technology Park Health and Welfare Benefit Plan hereafter referred to as ETTP

POLICY NUMBER: 70322

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Secretary President

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Certificate Specifications Page

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

GENERAL INFORMATION

POLICYHOLDER: URS | CH2M Oak Ridge LLC (UCOR) Plan Sponsor of the East Tennessee Technology Park Health and Welfare Benefit Plan hereafter referred to as ETTP

POLICY NUMBER: 70322

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in Tennessee.

POLICY EFFECTIVE DATE: January 1, 2018

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP: The group is composed of all active full-time and part-time benefit eligible employees of the policyholder and its associated companies working in the United States in the following classes:

Class 1 — All Active:
Salaried Employees: URS CH2M Oak Ridge LLC (UCOR), Fluor-BWXT Portsmouth LLC (FBWXT), Portsmouth Mission Alliance LLC (PMA), Four Rivers Nuclear Partnership, LLC (FRNP), and Wastren Advantage Inc. (WAI)
Bargaining Unit: URS CH2M Oak Ridge LLC (UCOR), Four Rivers Nuclear Partnership, LLC (FRNP), and Wastren Advantage Inc. (WAI)

Class 1D (Closed Group) — All Long Term Disability:
Salaried Employees: URS CH2M Oak Ridge LLC (UCOR), Fluor-BWXT Portsmouth LLC (FBWXT), Portsmouth Mission Alliance LLC (PMA), Four Rivers Nuclear Partnership, LLC (FRNP), and Wastren Advantage Inc. (WAI)
Bargaining Unit: URS CH2M Oak Ridge LLC (UCOR), Four Rivers Nuclear Partnership, LLC (FRNP), and Wastren Advantage Inc. (WAI)

Class 1R — All Retirees:
Salaried Employees: URS CH2M Oak Ridge LLC (UCOR), Fluor-BWXT Portsmouth LLC (FBWXT), Portsmouth Mission Alliance LLC (PMA), Four Rivers Nuclear Partnership, LLC (FRNP), and Wastren Advantage Inc. (WAI), Retired prior to January 1, 2001

Bargaining Units:

- URS CH2M Oak Ridge LLC (UCOR) – (Union Hourly ATLC Oak Ridge retired prior to July 1, 2001;
- Hourly Paducah PACE retired prior to August 1, 2001;
- Hourly Oak Ridge PACE retired prior to January 1, 2002);
- Four Rivers Nuclear Partnership, LLC (FRNP) retired prior to August 1, 2001; and
- Wastren Advantage Inc. (WAI) formerly PACE retired prior to August 1, 2001

NO DOUBLE COVERAGE: A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

ENROLLMENT PERIOD: Not applicable for noncontributory insurance; 31 days from the first day of eligibility for contributory insurance

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIRED: Full-time: 40 hours per week
Part-time: 8 hours

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE TERM LIFE INSURANCE:

Basic Life Insurance

Eligible Class	Amount of Basic Life Insurance
Classes 1 and 1D:	Two times annual earnings, (calculated as: basic annual earnings rounded to the next higher $1,000 if not already a multiple thereof and then multiplied by 2), subject to a maximum of $2,000,000.*
Class 1R	For an employee who retires prior to age 65, the employee may choose his or her benefit amount from the following options: Option 1: Pre Age 65 Retirement: An amount equal to the amount of basic life insurance in force on the date of retirement. This amount of insurance is continued until age 65 at which time the benefit is moved to the Age 65 and Post Age 65 Retirement benefit amount. Option 2: Age 65 and Post Age 65 Retirement: 20% of the basic life benefit on or before age 65. For an employee who retires on or after age 65, the benefit amount is equal to that as outlined in Option 2 above.

Supplemental Life Insurance
An employee must have Basic Life insurance in order to be eligible to elect any amount of supplemental life insurance from the following options:

Eligible Class	Amount of Supplemental Life Insurance
Classes 1 and 1D:	One, two, three, four or five times annual earnings, rounded to the next higher $1,000 if not already a multiple thereof and then multiplied, subject to a maximum of $500,000.*
Class 1R:	**For employees who retired according to the dates outlined below:** Salaried Employees: URS CH2M Oak Ridge LLC (UCOR), Fluor-BWXT Portsmouth LLC (FBWXT), Portsmouth Mission Alliance LLC (PMA), Four Rivers Nuclear Partnership, LLC (FRNP), and Wastren Advantage Inc. (WAI), Retired prior to January 1, 2001

Bargaining Units:

- URS CH2M Oak Ridge LLC (UCOR) – (Union Hourly ATLC Oak Ridge retired prior to July 1, 2001;
- Hourly Paducah PACE retired prior to August 1, 2001;
- Hourly Oak Ridge PACE retired prior to January 1, 2002);
- Four Rivers Nuclear Partnership, LLC (FRNP) retired prior to August 1, 2001; and
- Wastren Advantage Inc. (WAI) formerly PACE retired prior to August 1, 2001

For an employee who retires prior to age 65, the employee may choose his or her benefit amount from the following options:

Option 1: Pre Age 65 Retirement:
An amount equal to the amount of supplemental life insurance in force until age 65 or Post Age 65 Retirement benefit amount, subject to a maximum of $500,000.

Option 2: Age 65 and Post Age 65 Retirement:
10% of the supplemental life benefit on or before age 65.

For an employee who retires on or after age 65, the benefit amount is equal to that as outlined in Option 2 above.

For employees who retired on or after the dates outlined below:
Salaried Employees: URS CH2M Oak Ridge LLC (UCOR), Fluor-BWXT Portsmouth LLC (FBWXT), Portsmouth Mission Alliance LLC (PMA), Four Rivers Nuclear Partnership, LLC (FRNP), and Wastren Advantage Inc. (WAI), Retired prior to January 1, 2001

Bargaining Units:

- URS CH2M Oak Ridge LLC (UCOR) – (Union Hourly ATLC Oak Ridge retired prior to July 1, 2001;
- Hourly Paducah PACE retired prior to August 1, 2001;
- Hourly Oak Ridge PACE retired prior to January 1, 2002);
- Four Rivers Nuclear Partnership, LLC (FRNP) retired prior to August 1, 2001; and
- Wastren Advantage Inc. (WAI) formerly PACE retired prior to August 1, 2001

For employees who retired on or after the dates outlined above, there is no supplemental life benefit.

*The combined amount of basic and supplemental insurance for a class 1 or 1D employee shall not exceed $2,000,000.

GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

AGE REDUCTIONS:

The amount of basic life and supplemental life insurance on an employee age 65 or older shall be a percentage of the amount otherwise provided by the plan of insurance applicable to such employee in accordance with the following table:

Applies to Classes 1 and 1D only:

Age of Employee	Amount of Insurance
65	90%
66	80%
67	70%
68	60%
69 and over	50%

Age reductions will apply the first day of the month following an insured employee's applicable birthday.

RETIREMENT REDUCTIONS: All insurance terminates at retirement, except as provided for under the portability provision or as a Class 1R retiree.

CONTRIBUTORY/NONCONTRIBUTORY:

Applies to Classes 1 and 1D:
Basic insurance is noncontributory/contributory insurance based on associated companies plan design; supplemental insurance is contributory insurance.

Applies to Class 1R:

- Basic insurance Pre Age 65 Retirement is noncontributory/contributory insurance based on associated companies plan design;
- Basic insurance Age 65 and Post Age 65 Retirement: is noncontributory insurance;
- Supplemental insurance Pre Age 65 Retirement is noncontributory/contributory insurance based on associated companies plan design;
- Supplemental insurance Age 65 and Post Age 65 Retirement: is noncontributory insurance.

GUARANTEED ISSUE AMOUNT: The guaranteed issue is the maximum amount of insurance an employee can receive without evidence of insurability when first eligible under the plan provided enrollment is made within the enrollment period. The amounts are as follows:

Applies to Class 1 only: For basic insurance: $500,000

Applies to Class 1 only: For a combined basic and supplemental insurance: $500,000

NOTE: For an employee who was covered for supplemental life under the employer's plan immediately prior to the policy effective date shown above, the guaranteed issue for supplemental life is the amount of supplemental life in force under that prior plan immediately prior to the policy effective date.

EFFECTIVE DATE OF INCREASES AND DECREASES DUE TO CHANGE IN ELIGIBLE CLASS OR EARNINGS: Increases and decreases due to a change in eligible class or earnings will become effective the first day of the month following the date of the change in eligible class or earnings. Evidence of insurability will not be required for an increase in insurance due solely to an increase in earnings. All increases are subject to the actively at work requirement. NOTE: An employee whose amount of supplemental insurance is limited to the guaranteed amount of $500,000 due to being declined any amount of insurance by us under the group policy is not insured for a multiple of earnings plan, but rather is insured for the frozen amount of $500,000 and therefore will not receive an increase in supplemental insurance due to salary increases.

DEPENDENTS BENEFIT SCHEDULE

DEPENDENTS TERM LIFE INSURANCE:
An employee must notify us or the employer when a dependent is no longer eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

An employee does not need to be insured for supplemental life insurance in order to be insured for dependents life insurance.

Spouse Life Insurance

Eligible Class	Amount of Spouse Life Insurance
Classes 1 and 1D:	An amount elected by the employee, in an increment of $10,000, subject to a maximum of $100,000
Class 1R:	None

Child Life Insurance

Eligible Class	Amount of Child Life Insurance
Classes 1 and 1D:	$10,000
Class 1R:	None

GENERAL PROVISIONS FOR DEPENDENTS INSURANCE

SPOUSE AGE REDUCTIONS: The amount of insurance on an insured spouse age 65 or older shall be a percentage of the amount otherwise provided by the plan of insurance applicable to such spouse in accordance with the following table:

Applies to Classes 1 and 1D only:

Age of Spouse	Amount of Insurance
65	90%
66	80%
67	70%
68	60%
69 and over	50%

Age reductions will apply the first day of the month following an insured spouse's applicable birthday.

CONTRIBUTORY/NONCONTRIBUTORY: Dependents insurance is contributory insurance.

GUARANTEED ISSUE AMOUNT: The guaranteed issue is the maximum amount of insurance an eligible dependent can receive without evidence of insurability when first eligible under the plan provided enrollment is made within the enrollment period. The amounts are as follows:

For spouse insurance: $10,000
For child insurance: $10,000

NOTE: For employees with eligible dependents immediately prior to the policy effective date, the guaranteed issue amount is equal to the amount of dependents insurance for which they were insured under the prior group policy immediately prior to the policy effective date.

EFFECT OF EMPLOYEE'S RETIREMENT: All dependents insurance terminates upon the employee's retirement except as provided under the portability provision.

ADDITIONAL INFORMATION

WAIVER OF PREMIUM APPLICATION (Applies to Class 1 only): Applies to contributory and noncontributory employee insurance.

ELECTION CHANGES: Changes to your elections can only be made at annual open enrollment or within 31 days of a Qualified Status Change, as that term is defined by your employer. Coverage that does not require evidence of insurability will be effective on the date of the change in status for a Qualified Status Change, and on the following January 1 for an election change at annual enrollment. Coverage that requires evidence of insurability will be effective on the date it is approved by us for a Qualified Status Change or the later of the date it is approved by us or the following January 1 for a request made at annual enrollment.

EVIDENCE OF INSURABILITY: Evidence of insurability satisfactory to us will be required:

- In order for a newly eligible employee to become insured for an amount of insurance greater than the guaranteed issue amount. If such evidence of insurability is not provided or is not satisfactory to us, the employee will be insured for the guaranteed issue amount.

- In order for a newly eligible spouse to become insured for an amount of insurance greater than the guaranteed issue amount. If such evidence of insurability is not provided or is not satisfactory to us, the spouse will be insured for the guaranteed issue amount.
- At Qualified Status Change, a request that exceeds the amounts indicated below as not requiring evidence of insurability.
- At Qualified Status Change if the change is not in the list below in the "Certain Qualified Status Changes" section.
- At annual enrollment.

ONE TIME OPEN ENROLLMENT (Applies to Classes 1 and 1D only):

The employer will hold a one-time open enrollment prior to the policy effective date. During this enrollment, the following elections will not require evidence of insurability:

- An employee may elect or increase his or her supplemental life coverage by one times annual earnings, including enrolling for the first time at the one times earnings level, provided the resulting amount of insurance does not exceed $500,000
- An employee may elect or increase his or her spouse life insurance by one increment, including enrolling for the first time at the one times earnings level, provided the resulting amount of insurance does not exceed $10,000
- An employee may elect any child life amount

Coverage will be effective on the policy effective date, subject to the actively at work requirement for employees and the hospitalization/confinement clause for dependents.

CERTAIN QUALIFIED STATUS CHANGES (Applies to Classes 1 and 1D only):

An employee who experiences one of the Qualified Status Changes listed below may make the following election changes without providing evidence of insurability, provided enrollment is made within 31 days of the status change:

- An employee may elect or increase his or her supplemental life coverage by one times annual earnings, including enrolling for the first time at the one times earnings level, provided the resulting amount of insurance does not exceed $500,000
- An employee may elect any child life amount

Coverage will be effective on the date of the election, subject to the actively at work requirement for employees and the hospitalization/confinement clause for dependents.

Qualified Status Change for this purpose means:

- Birth or adoption or otherwise acquiring a newly eligible child
- Death of a dependent (spouse or child)
- Divorce, legal separation or annulment
- Marriage

CERTIFICATE SUPPLEMENTS (found later in this document):

Accelerated Benefits	Applies to all classes.
Dependents Term Life	Applies to Classes 1 and 1D only.
Portability	Applies to Class 1 only.
Waiver of Premium	Applies to Class 1 only.

Definitions

application

Your application for insurance under the group policy and, if required, your evidence of insurability application.

associated company

Any entity participating in the East Tennessee Technology Park Health and Welfare Benefit Plan, which is designated by the policyholder and agreed to by us to participate under the group policy.

contributory insurance

Insurance for which you are required to make premium contributions.

earnings

Your basic rate of compensation not including commissions, overtime or premium pay, bonuses, or any other additional compensation.

employee

An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner's principal work is the conduct of the partnership's business. The term employee does not include temporary employees or corporate directors who are not otherwise employees.

employer

The policyholder or any designated associated companies.

evidence of insurability

Evidence satisfactory to us of the good health of the prospective insured and any other underwriting information we require.

insured

A person who is eligible for and becomes insured according to the terms of this certificate, including any person insured by supplement to this certificate.

non-work day

A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long-term disability.

noncontributory insurance

Insurance for which you are not required to make premium contributions.

policyholder

The owner of the group policy as shown on the specifications page.

waiting period

The period, if any, of continuous employment with the employer required prior to becoming eligible for coverage under this certificate. The waiting period is shown on the specifications page. You are not eligible until the first day following the waiting period.

we, our, us

Securian Life Insurance Company.

you, your

An insured employee.

General Information

What is your agreement with us?

If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application as defined under this certificate is a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your life insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application as defined in this certificate will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

Can this certificate be amended?

Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

Who is eligible for insurance?

You are eligible if you:

(1) are a member of the eligible group and of an eligible class as shown on the specifications page; and
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and
(3) have satisfied the waiting period as shown on the specifications page; and

(4) meet the actively at work requirement as shown in the section entitled "What is the actively at work requirement?".

Are employees of associated companies eligible for insurance under the group policy?

Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder's acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to the policy terminating will apply to such employees.

Are retired employees eligible for insurance?

If the policyholder's plan of insurance, as reflected in the specifications page, does not specifically provide insurance for retired employees, a retired employee shall not be eligible to become insured, nor have his or her insurance continued. If the policyholder's plan of insurance specifically provides insurance for retired employees, the minimum hours per week and actively at work requirements will not apply to such persons.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the amount of insurance, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel.

If you are not working due to illness or injury you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your amount of insurance would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You will receive a refund of premium for any contributory insurance for which you were not eligible.

When will we require evidence of insurability?

The specifications page describes when evidence of insurability is required.

When does insurance become effective?

Insurance becomes effective on the date that all of the following conditions have been met:

(1) you meet all eligibility requirements; and
(2) for contributory insurance, you apply for the insurance in accordance with the application methods agreed upon by the policyholder and us; and
(3) we are satisfied with your evidence of insurability, if we require evidence.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer's practices and procedures, including the employer's limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment and is subject to the following maximum time frames:

(1) if you are on non-medical leave of absence or temporary layoff, insurance cannot be continued beyond 12 months from the last day you were actively at work.
(2) if you are on a medical leave of absence, insurance cannot be continued beyond the later of 12 months from the last day you were actively at work or attained age 65.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements. The above limits will be expanded if necessary in order to meet such requirements.

Premiums

When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a regular, periodic basis. We apply premiums consecutively to keep the insurance in force.

How is the premium determined?

The premium will be the applicable premium rate multiplied by the number of $1,000 units of insurance in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

Death Benefit

What is the amount of the death benefit?

The amount of the death benefit is equal to the amount of insurance for which you are insured, based on the plan of insurance applicable to your class as described on the specifications page, and your elections.

Can you request a change in the amount of your contributory insurance?

Yes. The specifications page describes when changes can be requested, when evidence of insurability will be required for such changes, and when the changes will become effective.

When will the death benefit be payable?

We will pay the death benefit upon receipt at our home office of written proof satisfactory to us as to both substance and form that you died while insured under this certificate. All payments by us are payable from our home office. The death benefit will be paid in a single sum or by any other method agreeable to us and the beneficiary.

To whom will we pay the death benefit?

We will pay the death benefit to the beneficiary or beneficiaries. You name a beneficiary to receive the death benefit to be paid at your death. You may name one or more beneficiaries. You can change the beneficiary designation at any time, provided all of the following are true:

(1) your coverage is in force; and
(2) we have written consent of all irrevocable beneficiaries; and
(3) you have not assigned the ownership of your insurance.

A beneficiary designation must be made in writing or by any other method made available under the plan. Any beneficiary designation shall take effect as of the date it is signed, but will not affect any payment we make or action we take before receiving the designation.

You may also choose to name a beneficiary that you cannot change without the beneficiary's consent. This is called an irrevocable beneficiary.

If there is more than one beneficiary, each will receive an equal share, unless you have requested another method in your beneficiary designation. To receive the death benefit, a beneficiary must be living at the time of your death. In the event a beneficiary is not living at the time of your death, that beneficiary's portion of the death benefit shall be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the death benefit will be paid as if you survived the beneficiary.

If there is no eligible beneficiary, or if you do not name one, we will pay the death benefit to:

(1) your lawful spouse if living; otherwise
(2) your natural or legally adopted child (children) in equal shares, if living; otherwise
(3) your parents in equal shares, if living; otherwise
(4) your natural or legally adopted siblings in equal shares, if living; otherwise
(5) your estate.

Termination

When does your coverage terminate?

Your coverage ends on the earliest of the following:

(1) the date the group policy ends; or
(2) the date you no longer meet the eligibility requirements; or
(3) the date the group policy is amended so you are no longer eligible; or
(4) 31 days (the grace period) after the due date of any premium contribution which is not paid; or
(5) the last day for which premium contributions have been paid following your written request to cease participation under this certificate.

Can your insurance be reinstated after termination?

Yes. When your coverage terminates because you are no longer eligible, and you become eligible again within three months after the date your coverage under this certificate terminated, your prior coverage may be reinstated, without evidence of insurability. If you die prior to our receipt of your reinstatement application and the required premium, no benefit will be paid.

When does the group policy terminate?

The policyholder may terminate the group policy by giving us 31 days prior written notice. We reserve the right to terminate the group policy on the earlier of the following to occur:

(1) 31 days (the grace period) after the due date of any premiums which are not paid; or
(2) 31 days after we provide the policyholder with notice of our intent to terminate the group policy.

Conversion Right

What is the conversion right?

You may be able to convert this insurance to a new individual life insurance policy if all or part of your life insurance under the group policy terminates due to the reasons listed below.

What is the full conversion right?

You may convert up to the full amount of terminated insurance if termination occurs because of termination of

employment or of membership in the class or classes eligible for coverage.

What is the limited conversion right?

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because:

(1) the group policy is terminated; or
(2) the group policy is changed, by amendment or otherwise, to reduce or terminate your insurance.

For a limited conversion, you may convert an amount up to the lesser of:

(1) $10,000; and
(2) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by us or any other carrier within 31 days of the date your insurance terminated under the group policy.

When is conversion not available?

Neither the full conversion right nor the limited conversion right is available if your coverage under the group policy terminates due to failure to make, when due, required premium contributions.

To what type of policy may you convert?

Under both the full conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by us for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits or accidental death and dismemberment benefits.

How do you convert your insurance?

You convert your insurance by applying for an individual policy and paying the first premium within 31 days after the date your group insurance terminates. No evidence of insurability will be required.

How is the premium for the individual policy determined?

The premium for the individual policy is based upon the individual policy type, risk class, coverage amount and your age on the date of conversion.

When is the individual policy effective?

The individual policy takes effect 31 days after the group insurance provided under the group policy terminates.

What happens if you die within 31 days of when your group insurance terminates?

If you die within 31 days of when your group insurance terminates, and meet the conversion eligibility requirements, we will pay a death benefit regardless of whether or not an application for coverage under an individual policy has been submitted. The death benefit will be the amount of insurance you would have been eligible to convert under the terms of the conversion right section. If you have completed a conversion application, we will pay the beneficiary designated on the conversion application. If you have not completed a conversion application, we will pay the beneficiary under your group insurance coverage.

We will return any premium you paid for an individual policy converted from this group insurance to your beneficiary as described above. In no event will we be liable under both the group policy and the individual policy.

Additional Information

What if your age has been misstated?

If your age has been misstated, the death benefit payable will be that amount to which you are entitled based on your correct age. A premium adjustment from any benefit payable will be made so that the actual premium required at your correct age is paid. If your correct age is such that no benefit is payable, you will receive a refund of premium for the period your eligibility would have ended.

Is there any cash value to this coverage?

No. This is term life insurance and it does not build cash value.

What is the suicide limitation?

If you, whether sane or insane, commit suicide within six months - two years from the effective date of any contributory life insurance, our liability with respect to that coverage will be limited to an amount equal to the premiums paid for the coverage.

If there has been an increase in your amount of contributory life insurance for which you were required to apply or for which we required evidence of insurability, and if you die by suicide within two years of the effective date of the increase, our liability with respect to that increase will be limited to the premiums paid and attributable to such increase.

Can your insurance coverage be contested?

Yes. If you die, or sustain a loss under one of your certificate supplements, within two years of your original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided by you during the application process. If we discover a material misrepresentation, your coverage will be rescinded and an otherwise valid claim will be denied. This two year period can be extended for fraud or as otherwise allowed by law.

Any statements you make in your application as defined under this certificate will, in the absence of fraud, be considered representations and not warranties. Also, any statement you make will not be used to void your insurance, nor defend against a claim, unless the statement is contained in the application.

Who is the owner of this coverage?

Unless assigned otherwise, you, the insured employee, are the owner of all coverage provided under your certificate. Only the owner has the right to exercise ownership rights under the certificate, including but not limited to naming or changing a beneficiary, changing the amount of insurance, assigning any or all ownership rights, converting coverage to an individual policy and terminating the coverage.

Can your insurance be assigned?

Yes. However, we will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written instrument, and you file the original instrument or a certified copy with us at our home office, and we send you an acknowledged copy.

We are not responsible for the validity of any assignment. You are responsible for ensuring that the assignment is legal in your state and that it accomplishes your intended goals. If a claim is based on an assignment, we may require proof of interest of the claimant. A valid assignment will take precedence over any claim of a beneficiary.

Can a change in ownership for a certificate be requested?

Yes. A change in ownership is a type of assignment. All provisions for assignments apply to ownership changes.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the group policy, and shall provide access to such records when required for us to administer the policy.

If an administrative or clerical error is made in keeping records on or administering the insurance under the group policy, it will not affect otherwise valid insurance. A clerical or administrative error, however, does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the amount of insurance provided by the provisions of the policy and no claim shall be paid on amounts put into effect as a result of a past clerical or administrative error. If an error causes a change in premium payment, a fair adjustment will be made.

Will the provisions of this certificate conform with state law?

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

What is the policy interpretation right and authority?

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.S. 1001 et seq.:

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life's exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.

Accelerated Benefits Certificate Supplement

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

Benefits received under this Accelerated Benefits Certificate Supplement may be taxable. You should seek assistance from a personal tax advisor prior to requesting an accelerated payment of death benefits.

General Information

This supplement is subject to every term, condition, exclusion, limitation, and provision of the certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for the accelerated payment of either the full or a partial amount of an insured's death benefit provided under your certificate. If an insured has a terminal condition as defined in this supplement, you may request an accelerated payment of the applicable death benefit. An accelerated payment will not include any accidental death or dismemberment benefit payable under an Accidental Death and Dismemberment Certificate Supplement. You must give notice of claim while living and while your life insurance coverage is in force to be eligible for consideration of an accelerated benefit.

What is a terminal condition?

A terminal condition is a condition caused by sickness or accident which directly results in a life expectancy of 12 months or less. We must be given medical evidence in substance and in form that satisfies us that the insured has a terminal condition. That evidence must include certification by a physician. For purposes of this supplement, a physician is an individual who is licensed to practice medicine or treat illness in the state in which treatment is received. The physician cannot be you or your spouse, children, parents, grandparents, grandchildren, brothers or sisters; or the spouse of any such individuals.

Accelerated Benefit

Who may request an accelerated payment of the death benefit?

You may request an accelerated payment of the insurance on your life or on the life of a spouse or dependent child insured under your certificate.

When can an accelerated benefit be requested?

An accelerated benefit can be requested any time, provided the following conditions are met:

(1) the insurance is in force and all premiums due are fully paid; and
(2) you have not assigned and are the sole owner of the certificate; and
(3) the certificate does not have an irrevocable beneficiary.

Is there a minimum or maximum death benefit eligible for an accelerated benefit?

Yes. The minimum death benefit to be eligible for an accelerated benefit under this supplement is $10,000. The maximum death benefit that can be accelerated is $1,000,000.

Is a partial accelerated benefit available?

Yes. You may choose to accelerate only a portion of an insured's death benefit, providing the remaining amount of insurance is at least $25,000. This is called a partial accelerated benefit.

You may reapply for the payment of the remaining amount of insurance at any time. However, the total amount of the death benefit for all accelerated benefit payments for an insured cannot exceed $1,000,000. We may ask for further evidence satisfactory to us in substance and in form that the insured meets all requirements for the accelerated benefit.

When will we pay an accelerated benefit?

We will pay an accelerated benefit upon receipt at our home office of written proof satisfactory to us in substance and in form that the insured meets the requirements herein.

The accelerated benefit will be paid in a single sum or by any other method agreeable to you and us.

To whom will we pay accelerated benefits?

We will pay the accelerated benefit to you unless you validly assign it otherwise. If you die before we issue payment of an accelerated benefit to you, we will pay the life insurance benefits to your life insurance beneficiary(s).

What is the effect on the insured's coverage of the receipt of an accelerated benefit?

If you elect to accelerate the full amount of an insured's death benefit, the insured's coverage and all other benefits under the certificate and any certificate supplements for that insured will end. If it is your death benefit being accelerated, any dependent life insurance will terminate, though it may be converted to a policy of individual life insurance according to the conversion right section of the certificate.

If a partial accelerated benefit is chosen, coverage will remain in force and premiums will be reduced accordingly. The remaining amount of insurance under the certificate will be the full amount of insurance minus the amount of insurance that was accelerated.

Termination

When does an insured's coverage under this supplement terminate?

An insured's accelerated benefits coverage terminates on the earliest of:

(1) the date the insured is no longer insured for life insurance under the certificate; or
(2) the date the accelerated benefits coverage is terminated for the policyholder's plan; or
(3) the date the group policy is terminated.

Additional Information

Is the request for an accelerated benefit voluntary?

Yes. An accelerated benefit will be made available on a voluntary basis only. An accelerated benefit under this supplement is not intended to cause an involuntary reduction of the death benefit ultimately payable to the beneficiary. Therefore, an accelerated benefit is not available if you:

(1) are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
(2) are required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

Do we have the right to obtain independent medical verification?

Yes. Although you are responsible for submitting proof satisfactory to us that you meet the requirements for the accelerated benefit, we do retain the right to have an insured medically examined at our expense to verify the insured's medical condition. We may do this as often as reasonably required while an accelerated benefit is being considered or paid.

Secretary

President

Dependents Term Life Insurance Certificate Supplement

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

General Information

This certificate supplement is issued in consideration of the required premium and is subject to every term, condition, exclusion, limitation, and provision of your certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides insurance on the lives of your eligible dependents.

What members of your family are eligible for insurance under this supplement?

The following members of your family are eligible for insurance under this supplement:

(1) your lawful spouse who is not legally separated from you; and
(2) your or your spouse's natural, legally adopted, a child for whom benefits must be provided by court order, or stepchildren who are less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible). Children age 26 or older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and are financially dependent on the employee for more than one-half of their support and maintenance.

A person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

Any dependent who, subsequent to the effective date of your dependents term life insurance, meets the eligibility requirements of this supplement will become insured on the date he or she so qualifies, provided no additional premium is required and the dependent is not hospitalized or confined because of illness or disease (except in the case of a newborn). If additional premium is required, the insurance for that dependent will be effective under the same conditions which would apply if you were newly becoming eligible for dependents term life insurance under this supplement. If the dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement (except in the case of a newborn).

When will we require evidence of insurability?

The specification page describes when evidence of insurability will be required.

When does insurance on a dependent become effective?

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

(1) the dependent meets all eligibility requirements; and
(2) for contributory coverage, you apply for dependents coverage in accordance with the application methods agreed upon by the policyholder and us; and
(3) we are satisfied with the dependent's evidence of insurability, if we require evidence.

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child. However, in no event will insurance on a dependent be effective before your insurance is effective.

Death Benefit

What is the amount of life insurance on each insured dependent?

The amount of life insurance on each insured dependent is shown on the specifications page.

To whom will we pay the death benefit?

The death benefit payable under this supplement will be paid to you if living, otherwise to your estate.

Termination

When does an insured dependent's coverage under this supplement terminate?

An insured dependent's coverage ends on the earliest of the following:

(1) the date your spouse attains age 70 or the date the dependent no longer meets the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium contribution which is not paid; or
(3) the last day for which premium contributions have been made following your written request that

insurance on your eligible dependents be terminated; or

(4) the date you are no longer covered under the group policy; or
(5) the date this supplement terminates.

When does this supplement terminate?

This supplement will terminate on the earlier of:

(1) the date requested by the policyholder to cancel the Dependents Term Life coverage for its plan; or
(2) the date the group policy is terminated.

Additional Information

What is the conversion right under this supplement?

If an insured dependent's coverage under this supplement terminates because he or she is no longer eligible, or because of your death, or because of termination or amendment of this supplement, the insurance may be converted to a policy of individual insurance with us.

Conversion may be requested by you, an insured dependent of legal capacity, or the insured dependent's guardian, if applicable. All other conditions and provisions of the conversion right section of your certificate to which this supplement is attached will apply.

What is the suicide limitation?

If an insured dependent, whether sane or insane, commits suicide within six months – two years from the effective date of any contributory life insurance, our liability with respect to that coverage will be limited to an amount equal to the premiums paid for the coverage.

If there has been an increase in an insured dependent's amount of contributory life insurance for which you were required to apply or for which we required evidence of insurability, and if the dependent dies by suicide within two years of the effective date of the increase, our liability with respect to that increase will be limited to the premiums paid and attributable to such increase.

The suicide exclusion does not apply to an insured child.

Does the Waiver of Premium supplement to your certificate apply to insured dependents?

The Waiver of Premium supplement to your certificate will not apply to disabilities for dependents covered under this supplement.

However, if, due to your disability, your insurance is continued in force without further payment of premiums due to the Waiver of Premium supplement, any dependents insurance provided by this supplement shall also continue in force without further payment of premiums until the dependent's eligibility terminates or until your insurance is no longer continued in force due to the Waiver of Premium supplement.

This provision is not applicable if the dependent's insurance has been converted under the conversion right section of this supplement, unless the converted policy is surrendered without claim except for refund of premiums.

Secretary

President

Portability
Certificate Supplement

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

General Information

This certificate supplement is issued in consideration of the required premium and is subject to every term, condition, exclusion, limitation and provision of the certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for continuation of insurance if an insured no longer meets the eligibility requirements of the certificate, except as provided for herein.

To continue insurance, the insured must make a written request and make the first premium payment within 31 days after insurance provided by the group policy would otherwise terminate. Evidence of insurability will not be required. Coverage provided by this supplement will be effective the date we receive the completed application. This date is considered to be the insured's portability date and the insured is then considered to have portability status.

Who is eligible to continue insurance under this supplement?

An insured employee is eligible to continue group life insurance under the terms of this supplement if he or she no longer meets the eligibility requirements of the certificate due to any of the following:

(1) the employee terminates employment, including retirement; or
(2) the employee is no longer in a class eligible for insurance or is on a leave or layoff; or
(3) a class or group of employees insured under the policy is no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under this policy.

An insured will not be eligible to request coverage under this supplement if he or she:

(1) has attained the age of 80; or
(2) has converted his or her insurance to an individual life policy under the terms of the certificate's conversion right section; or
(3) was not actively at work due to sickness or injury on the date immediately preceding his or her portability date; or
(4) loses eligibility due to termination of the group policy.

Can insurance that is lost due to moving from one eligible class to another be ported?

No, with one exception: if an employee moves from an active class to a retiree class, he or she can port the amount of insurance lost due to the change in class, subject to all the provisions of this supplement.

What insurance can be continued under this supplement?

Only contributory insurance may be continued under this supplement.

An insured may also continue coverage under all certificate supplements which apply to his or her contributory insurance and by which he or she was insured immediately preceding his or her portability date, except the Waiver of Premium Certificate Supplement and Dependent Term Life Insurance Certificate Supplement, which shall terminate upon porting.

Is there a minimum amount of insurance that can be continued under this supplement?

Yes. The minimum amount of insurance that can be continued on an employee's life under this supplement is $10,000.

Is there a maximum amount of insurance that can be continued under this supplement?

Yes. The maximum amount of insurance that can be continued under this supplement is the amount of insurance that was in force on the insured's portability date, but not more than $1,000,000 for an employee. However, for an insured age 65 or older on his or her portability date, the amount will not be more than $650,000 for an employee.

Will the amount of insurance continued under this supplement change?

Yes. On the first day of the month following the date an insured attains age 65, the amount of insurance on his or her life continued under this supplement will reduce to 65% of the amount of insurance in force on the day prior to attainment of age 65. Insurance terminates at age 80.

Can an insured request a change in the amount of insurance continued under this supplement?

Yes. An insured may elect to reduce the amount of insurance on his or her life, subject to the minimum amount. The amount of insurance continued under this supplement will never increase.

How will premium contributions be paid?

Premium contributions will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period. We may adjust the amount of the charge, but not more often than once per year.

Can the premium rate change?

Yes. The premium rate may increase on the portability date. The premium rate may also increase in the future.

Can insurance continued under this supplement be converted to a policy of individual insurance?

Yes. At any time after insurance has been continued under the provisions of this supplement, but not beyond 31 days after coverage terminates under the provisions of this supplement, it may be converted to a policy of individual insurance with us. All other conditions and provisions of the conversion right section of the certificate to which this supplement is attached will apply. Coverage cannot be continued under both this supplement and the conversion privilege.

What happens if an insured again becomes eligible under the certificate?

If an insured is continuing coverage under the terms of this supplement, and again meets the eligibility requirements of the certificate, the insured shall no longer be considered to have portability status, ported coverage will terminate and only one death benefit will be paid under the coverage. Insurance may be continued only under the terms of the certificate, not including this supplement unless and until the insured no longer meets the eligibility requirements of the certificate and again return to portability status as provided for herein.

What happens to insurance provided under this supplement when the group policy terminates?

Anything in the group policy notwithstanding, termination of the group policy will not terminate life insurance then in force for any person under the terms of this supplement. The group policy will be deemed to remain in force solely for the purpose of continuing such insurance, but without further obligation of the policyholder.

Any insurance continued under the terms of this supplement will remain in force until terminated by the provisions of the section entitled “When will insurance continued under this supplement terminate?”.

No individual may elect coverage under this supplement on or after the date of termination of the group policy.

When will insurance continued under this supplement terminate?

Insurance being continued under this supplement will terminate on the earliest of the following:

(1) the insured’s 80th birthday; or
(2) the date the insured again meets the eligibility requirements of the certificate, not including the terms of this supplement; or
(3) 31 days after the due date of any premium contribution which is not made; or
(4) the date an insured requests to terminate his or coverage being continued under this supplement.

Secretary President

Waiver of Premium
Certificate Supplement

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

General Information

This certificate supplement is subject to every term, condition, exclusion, limitation, and provision of your certificate unless otherwise expressly provided for herein. Coverage under this supplement will not be included in any insurance issued under the conversion right section of your certificate.

The specifications page indicates to what insurance this supplement applies. This supplement does not apply to you if you have portability status.

What does this supplement provide?

This supplement provides for waiver of premium if you become totally disabled, as defined herein. Upon approval of proof of such disability, your insurance, including all supplements to your certificate which were in force on the date of the onset of your disability, will be continued in force without payment of premiums during the uninterrupted continuance of the total disability.

What is total disability?

You are considered totally disabled if you are eligible for and receiving disability income benefits under the employer's long term disability (LTD) plan. The disability for which LTD benefits are ultimately payable must commence while your insurance is in force under the group policy.

What if you convert your group life insurance to a policy of individual insurance prior to the approval of your disability claim?

If your coverage has been converted in accordance with the conversion right section of your certificate, benefits under this supplement will apply only if the converted policy is surrendered without claim, except for refund of premiums. You cannot have coverage under both policies and only one death benefit will be available.

What will be considered due proof of total disability?

You must furnish evidence satisfactory to us as to both substance and form that your disability:

(1) commenced while your insurance under your certificate was in force; and
(2) meets the definition of total disability.

We will, from time to time, also require additional proof satisfactory to us that you continue to be totally disabled.

After you have provided at your expense the requested claim forms and records, we may also require that you submit to one or more medical examinations at our expense.

If you die within one year of the date of onset of your total disability, your beneficiary may claim benefits under this supplement even if your premium payments were discontinued and you had not submitted due proof satisfactory to us of your total disability. Your beneficiary must submit due proof satisfactory to us that your total disability, which began before premium payments on your behalf were discontinued, continued without interruption until your death.

When must we be notified of your disability or death?

We must receive written notice at our home office of your total disability within one year of the date of onset of such disability. However, failure to give notice within the time provided will not invalidate the claim if it is shown that notice was given as soon as reasonably possible.

We must receive written notice at our home office within one year of death that you died during a period of continuance provided by this supplement. Proof must be furnished that you continued to be totally disabled during the entire period of continuance until death. If such notice and proof are not provided within the required time frame, there shall be no liability for any payment under this supplement. However, failure to give notice within the time provided will not invalidate the claim if it is shown that notice was given as soon as reasonably possible.

What is the amount of insurance to be continued without payment of premium under this supplement?

The amount of insurance continued without payment of premium shall be the amount of insurance that was in force on the date of onset of total disability.

If the group policy provides for reductions in amounts of insurance based on age or retirement, such reductions shall apply to your insurance while disabled.

How long will insurance be continued without payment of premium?

If you become totally disabled, insurance will be continued, without payment of premium, until the earliest of:

(1) the date you recover so that you are no longer totally and permanently disabled; or

(2) the date you are no longer receiving LTD benefits; or
(3) the date you fail to furnish proof of continued disability when requested or you refuse to submit to a required medical examination.

What happens to your insurance when the waiver of premium benefit ends?

When the benefits under this supplement end according to the provisions of the section entitled "How long will insurance be continued without payment of premium?," the following will apply:

(1) If you are then eligible for coverage under your certificate, your insurance may be continued under your certificate provided that premiums are paid. The first such premium payment must be made within 31 days of the date the waiver of premium benefit ends.
(2) If you are no longer eligible for coverage under your certificate, you may convert coverage to an individual policy, as provided for under the conversion right section of your certificate.

Your insurance will end unless, within 31 days of the date benefits under this supplement end, premium payments on your behalf are resumed or you apply to convert your coverage.

Termination

When does your coverage under this supplement terminate?

Your waiver of premium coverage terminates on the earliest of:

(1) the date you are no longer insured for life insurance covered by this supplement; or
(2) the date requested by the policyholder to cancel the Waiver of Premium coverage for its plan; or
(3) the date the group policy is terminated.

Insurance being continued without further payment of premiums in accordance with the provisions of this supplement will not end due solely to the termination of the Waiver of Premium coverage or of the group policy.

Secretary

President

Waiver of Premium
Certificate Supplement

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

General Information

This certificate supplement is subject to every term, condition, exclusion, limitation, and provision of your certificate unless otherwise expressly provided for herein. Coverage under this supplement will not be included in any insurance issued under the conversion right section of your certificate.

The specifications page indicates to what insurance this supplement applies. This supplement does not apply to you if you have portability status.

What does this supplement provide?

This supplement provides for waiver of premium if you become totally and permanently disabled, as defined herein, while under age 69. Upon approval of proof of such disability, your insurance, including all supplements to your certificate which were in force on the date of the onset of your disability, will be continued in force without payment of premiums during the uninterrupted continuance of the total and permanent disability.

What is total disability?

Total disability is a disability which occurs while your insurance is in force and which results from an accidental injury or an illness that continuously prevents you from engaging in any occupation for which you are reasonably suited by education, training, or experience on a full or part time basis. You must be under the care of a licensed physician. The licensed physician cannot be you or a member of your immediate family. For purposes of this supplement, your immediate family consists of your spouse, children, parents, grandparents, grandchildren, brothers and sisters, and their spouses.

During the first 24 months of total disability, occupation means your regular occupation. After 24 months, it means any occupation for which you are reasonably suited by education, training, or experience.

What is permanent disability?

Permanent disability is a total disability which has existed continuously for at least six months.

Are there any limitations?

Yes. Insurance will not be continued if your disability results from intentionally self-inflicted injury, participation in or any attempt to commit a crime, or war or any act of war, whether declared or undeclared.

What if you convert your group life insurance to a policy of individual insurance prior to the approval of your disability claim?

If your coverage has been converted in accordance with the conversion right section of your certificate, benefits under this supplement will apply only if the converted policy is surrendered without claim, except for refund of premiums. You cannot have coverage under both policies and only one death benefit will be available.

What will be considered due proof of total and permanent disability?

You must furnish evidence satisfactory to us as to both substance and form that your disability:

(1) commenced while your insurance under your certificate was in force; and
(2) meets the definition of total disability; and
(3) commenced before your 69th birthday; and
(4) was continuous for six months or more.

We will, from time to time, also require additional proof satisfactory to us that you continue to be totally and permanently disabled. After you have provided at your expense the requested claim forms and records, we may also require that you submit to one or more medical examinations at our expense.

If you die within one year of the date of onset of your total disability, your beneficiary may claim benefits under this supplement even if your premium payments were discontinued and you had not submitted due proof satisfactory to us of your total disability or you were continuously disabled for less than six months. Your beneficiary must submit due proof satisfactory to us that your total disability, which began before premium payments on your behalf were discontinued and before your 69th birthday, continued without interruption until your death.

When must we be notified of your disability or death?

We must receive written notice at our home office of your total disability within one year of the date of onset of such disability. However, failure to give notice within the time provided will not invalidate the claim if it is shown that notice was given as soon as reasonably possible.

We must receive written notice at our home office within one year of death that you died during a period of continuance provided by this supplement. Proof must be furnished that you continued to be totally disabled during the entire period of continuance until death. If such notice and proof are not provided within the required time frame, there shall be no liability for any payment under this supplement. However, failure to give notice within the time provided will not invalidate the claim if it is shown that notice was given as soon as reasonably possible.

What is the amount of insurance to be continued without payment of premium under this supplement?

The amount of insurance continued without payment of premium shall be the amount of insurance that was in force on the date of onset of total disability.

If the group policy provides for reductions in amounts of insurance based on age or retirement, such reductions shall apply to your insurance while disabled.

How long will insurance be continued without payment of premium?

If you become totally and permanently disabled, insurance will be continued, without payment of premium, until the earliest of:

(1) the maximum benefit duration has been reached:

The maximum benefit duration is in accordance with the following schedule:

Age at Disability	Maximum Benefit Duration
Less than 60	Age 65
Ages 60 – 69	The lesser of 60 months or age 70. The duration of benefits will never be less than 12 months.

; or

(2) the date you recover so that you are no longer totally and permanently disabled; or
(3) the date you fail to furnish proof of continued disability when requested or you refuse to submit to a required medical examination.

What happens to your insurance when the waiver of premium benefit ends?

When the benefits under this supplement end according to the provisions of the section entitled "How long will insurance be continued without payment of premium?," the following will apply:

(1) If you are then eligible for coverage under your certificate, your insurance may be continued under your certificate provided that premiums are paid. The first such premium payment must be made within 31 days of the date the waiver of premium benefit ends.
(2) If you are no longer eligible for coverage under your certificate, you may convert coverage to an individual policy, as provided for under the conversion right section of your certificate.

Your insurance will end unless, within 31 days of the date benefits under this supplement end, premium payments on your behalf are resumed or you apply to convert your coverage.

Termination

When does your coverage under this supplement terminate?

Your waiver of premium coverage terminates on the earliest of:

(1) the date you are no longer insured for life insurance covered by this supplement; or
(2) the date requested by the policyholder to cancel the Waiver of Premium coverage for its plan; or
(3) the date the group policy is terminated.

Insurance being continued without further payment of premiums in accordance with the provisions of this supplement will not end due solely to the termination of the Waiver of Premium coverage or of the group policy.

Secretary

President

Group Term Life Insurance
Certificate Endorsement

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 70322, issued by Securian Life Insurance Company to URS | CH2M Oak Ridge LLC (UCOR) Plan Sponsor of the East Tennessee Technology Park Health and Welfare Benefit Plan hereafter referred to as ETTP, hereafter referred to as ETTP. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to all employees:

1. The provision entitled **What is your agreement with us?** under the **General Information** section of the certificate is amended in its entirety and replaced with the following:

   What is your agreement with us?

   If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application as defined under this certificate is a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your life insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

   Any statements made in your application as defined in this certificate will be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

2. The provision entitled "**Can your insurance coverage be contested?**" under the **Additional Information** section of the certificate is amended in its entirety and replaced with the following:

   Can your insurance coverage be contested?

   Yes. If you die, or sustain a loss under one of your certificate supplements, within two years of your original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided by you during the application process. If we discover a material misrepresentation, your coverage will be rescinded and an otherwise valid claim will be denied.

   Any statements you make in your application as defined under this certificate will be considered representations and not warranties. Also, any statement you make will not be used to void your insurance, nor defend against a claim, unless the statement is contained in the application.

3. The provision entitled "**How do you convert your insurance?"** under the **Conversion Right** section of the certificate is amended to include the following:

   You convert your insurance by applying for an individual policy and paying the first premium within 31 days after the date your group insurance terminates. No evidence of insurability will be required.

   If you do not receive written notice of the conversion right under this certificate at least 15 days prior to the end of the 31-day conversion period, you will have an additional period within which to exercise such right. This additional period will expire 15 days after you are given such notice, but in no event will such additional period be extended beyond 60 days after the end of the conversion period. Notice of the conversion right will be presented to you or sent to your last known address. Receipt of this certificate will constitute such notice. Nothing contained herein will be construed to continue any insurance beyond the period provided in this certificate.

4. The provision entitled **"When will the death benefit be payable?"** under the **Death Benefit** section of the certificate is deleted in its entirety and replaced with the following:

   We will pay the death benefit within two months after receipt at our home office of written proof satisfactory to us as to both substance and form that you died while insured under this certificate. All payments by us are payable from our home office. The death benefit will be paid in a single sum or by any other method agreeable to us and the beneficiary.

Secretary

President

Notice

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

NOTICE CONCERNING COVERAGE UNDER THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

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LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point;
- $500,000 for basic hospital, medical and surgical insurance, and major medical insurance issued by companies that become insolvent after January 1,2010.

With these overall limits, the Guaranty Association cannot guarantee payment of benefits greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30,2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - $100,000 for limited benefits and supplemental health coverages
  - $300,000 for disability and long term care insurance
  - $500,000 for basic hospital, medical and surgical insurance, or major medical insurance

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, TN 37219-2433

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

Notice

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, and is not available at all for some policies.

COVERAGE IS NOT PROVIDED FOR YOUR POLICY OR ANY PORTION OF IT THAT IS NOT GUARANTEED BY THE INSURER OR FOR WHICH YOU HAVE ASSUMED THE RISK, SUCH AS A VARIABLE CONTRACT SOLD BY PROSPECTUS.

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Tennessee Notice

Securian Life Insurance Company
400 Robert Street North ● St. Paul, Minnesota 55101-2098

SECURIAN®

In the event you need to contact someone regarding this policy, you may contact the insurance company issuing this policy at the following address and telephone number.

Securian Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098

Telephone: (651) 665-3500

Securian Life Insurance Company • A Stock Company

400 Robert Street North • St Paul, Minnesota 55101-2098

GROUP TERM LIFE CERTIFICATE OF INSURANCE