BENEFIT PLAN

Prepared Exclusively For
President and Trustees of Bates College

Open Choice (PPO Medical Plan) with HSA

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder
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* Defines the Terms Shown in Bold Type in the Text of This Document.
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.

Group Policyholder: President and Trustees of Bates College
Group Policy Number: GP-869807
Effective Date: January 1, 2015
Issue Date: June 16, 2015
Booklet-Certificate Number: 3

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)
Important Information Regarding Availability of Coverage (GR-9N 02-005 02)
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-02-005-01 ME)

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

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 ME)
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 (GR-9N.29.005-02)
You are in an eligible class if:

- You are a regular full-time employee, as defined by your employer.
- You are a retired employee of an employer participating in this plan, and you:
  - Retired before the effective date of this plan and were covered under the prior plan for health care coverage on the day before you retired; or
  - Were covered under this plan or another plan sponsored by your employer on the day before you retired; and
  - Retire under your employer’s IRS-qualified retirement plan.

Probationary Period (GR-9N-29.005-02)
Once you enter an eligible class, you will need to complete the probationary period before your coverage under this plan begins.

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 or enter an eligible class after the effective date of this plan, your coverage eligibility date is the first day of the month coinciding with or next following the date you complete 1 month of continuous service with your employer. This is defined as the probationary period. If you had already satisfied the probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents (GR-9N.29.010.01 ME)
Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; or
- Your domestic partner who meets the rules set by the state of Maine; and
- Your dependent children; and
- Dependent children of your domestic partner.

**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 Domestic Partner** *(GR-9N-29-010-01 ME)*
To be eligible for coverage, you and your domestic partner will need to complete and sign a Declaration of Domestic Partnership.

**Coverage for Dependent Children** *(GR-9N-29-010-06)*
To be eligible for coverage, a dependent child must be under 26 years of age.

*(GR-9N-29-010-06)*
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.
- Any other child with whom you have 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 ME)*

**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
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
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  

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; and
- The date you return your completed enrollment information; and
- Your application is received and approved in writing by Aetna; and
- The date your required contribution is received by Aetna.

If you do not return your completed enrollment information 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
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

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

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 PPO Comprehensive Medical Plan

This Preferred Provider Organization (PPO) medical 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 PPO 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 PPO 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 PPO 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.

You also have the choice to access licensed providers, hospitals and facilities outside the network for covered benefits. Your out-of-pocket costs will generally be higher. Deductibles, copayments, 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.

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 PPO plan, please carefully review the following information.

How Your PPO Plan Works

Accessing Network Providers and Benefits

- You may select any network provider from the Aetna network provider directory or by logging on to Aetna’s website, 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 health care provider at any time.
- If a service you need is covered under the plan but not available from a network provider, please contact Member Services 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 is no additional out-of-pocket cost to you as a result of a network provider’s failure to precertify services. Refer to the Understanding Precertification section for more information.
- You will not have to submit medical claims for treatment received from network providers. Your network provider will take care of claim submission. Aetna will directly pay the network provider less any cost sharing required by you. You will be responsible for deductibles, coinsurance, and copayment, if any.
- You will receive notification of what the plan has paid toward your covered expenses. It will indicate any amounts you owe toward your deductible, copayment, 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

Important Note:
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 deductible before the plan will begin to pay benefits.

- For certain types of services and supplies, you will be responsible for any copayment shown in the Schedule of Benefits.

- After you satisfy any applicable deductible, you will be responsible for your 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 your Schedule of Benefits section for information on what specific limits apply to your plan.

- 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.

- You may be billed for any deductible, copayments, or coinsurance amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits

- You have the choice to directly access physicians, hospitals or other health care providers that do not participate with the Aetna provider network. You will still be covered when you access out-of-network providers for covered benefits. Your out-of-pocket costs will generally be higher.

- 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. Deductibles and coinsurance are usually higher when you utilize out-of-network providers. Except for emergency services, Aetna will only pay up to the recognized charge.

- 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 or may not be covered. This means you will be responsible for the unpaid balance of any bills. 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 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 by you.

- If your out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred above the recognized charge. The recognized charge is the maximum amount Aetna will pay for a covered expense from an out-of-network provider.

- You will receive notification of what the plan has paid toward your medical 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 for information on how to **precertify** and the **precertification** benefit reduction.

**Cost Sharing for Out-of-Network Benefits**

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

- You must satisfy any **deductibles** before the plan begins to pay benefits.

- 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 **Schedule of Benefits** section for information on what expenses do not apply and for the specific dollar limits that apply to your plan.

- The plan will pay for **covered expenses**, up to the maximums shown in the **What the Plan Covers** or **Schedule of Benefits** section. You are responsible for any expenses incurred over the maximum limits outlined in the **What the Plan Covers** or the **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:

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

**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.08.065.04 ME)**

**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 for treatment of mental disorders, alcoholism or drug abuse treatment
- Home health care
- Private duty nursing care

**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.

<table>
<thead>
<tr>
<th>If precertification is:</th>
<th>then the expenses are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ requested and approved by Aetna</td>
<td>▪ covered.</td>
</tr>
<tr>
<td>▪ requested and denied.</td>
<td>▪ not covered, may be appealed.</td>
</tr>
<tr>
<td>▪ not requested, but would have been covered if</td>
<td>▪ covered after a precertification benefit reduction is</td>
</tr>
<tr>
<td>requested.</td>
<td>applied.*</td>
</tr>
<tr>
<td>▪ not requested, would not have been covered if</td>
<td>▪ not covered, may be appealed.</td>
</tr>
<tr>
<td>requested.</td>
<td></td>
</tr>
</tbody>
</table>

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 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 ME)
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 physician provided a delay would not be detrimental to your health.
▪ After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
▪ If you are admitted to an inpatient facility, notify your physician 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)
Call your physician if you think you need urgent care. Network providers are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any physician or urgent care provider, in- or out-of-network, for an urgent care condition if you cannot reach your physician.
If it is not feasible to contact your **network provider**, 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 provided by a **network provider**.

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 ME)

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 health care must be medically necessary. “Medically necessary health care” means health care services or products provided to an enrollee for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:
   (a) Consistent with generally accepted standards of medical practice;
   (b) Clinically appropriate in terms of type, frequency, extent, site and duration;
   (c) Demonstrated through scientific evidence to be effective in improving health outcomes;
   (d) Representative of “best practices” in the medical profession; and
   (e) Not primarily for the convenience of the enrollee or physician or other health care practitioner.

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

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

PPO Medical 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

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

Routine Physical Exams

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

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics; and
- Testing for Tuberculosis.

Covered expenses for children from birth to age 18 also include:

- An initial hospital check up and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

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

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

Important Reminder

Refer to the Schedule of Benefits for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for physical exams.
Routine Cancer Screenings

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

- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap smear every 12 months or as recommended by a physician;
- 1 gynecological exam every 12 months including a rectovaginal pelvic exam for women age 25 and over who are at risk for ovarian cancer;
- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 50 to 72.
- colorectal cancer screening for asymptomatic individuals who are: 50 years of age or older; or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. Colorectal cancer screening means a colorectal cancer examination and laboratory test (colonoscopy) recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

The following tests are covered expenses if you are age 50 and older when recommended by your physician:

- 1 Sigmoidoscopy every 5 years for persons at average risk; or
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk.

Family Planning Services (GR-9N S-11-005-02 ME)

Covered expenses include charges for certain contraceptive and family planning services, even though not provided to treat an illness or injury. Refer to the Schedule of Benefits for any frequency limits that apply to these services, if not specified below.

Contraception Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a physician provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Other Family Planning

Covered expenses include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

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

Also see section on pregnancy and infertility related expenses on a later page.
Vision Care Services (GR-9N S-11-10-01 ME)

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 12 consecutive month period.

Limitations

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

Physician Services (GR-9N-11 020 01 ME)

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, in a hospital, or other facility during your stay or in an outpatient facility.

Covered expenses include those for telemedicine services. Coverage shall not be denied on the basis that the coverage is provided through telemedicine if the health care service would be covered if it were provided through in-person consultation between the covered person and a health care provider. Coverage is provided for only those services that are medically necessary, subject to the terms and conditions of this plan for covered health care services provided through in-person consultation. "Telemedicine", as it pertains to the delivery of health care services, means the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. "Telemedicine" does not include the use of audio-only telephone or facsimile machine or e-mail.

Covered expenses also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by the physician for supplies, radiological services, x-rays, and tests provided by the physician.

Surgery

Covered expenses include charges made by a physician for:

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

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 Reminder

Certain procedures need to be precertified by Aetna. Refer to How the Plan Works 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 11 030 ME)*

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, surgeons and registered nurse first assistants.
- 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:11.030 01)*
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
Covered expenses include charges made by a hospital or a physician for services provided in an emergency room to evaluate and treat an emergency medical condition.

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 a network provider 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
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 a network provider 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

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 S-11-045 01 ME)**
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.

**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 ME)**
Covered expenses include charges for home health care services when ordered by a physician as part of a home health plan.
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.
- 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. One home health care visit shall be:

- Each visit by a nurse, therapist, or physicians to a person's home.
- Each visit by a person to a physician’s office.
- Each visit up to 4 hours by a home health aide.

In figuring the Calendar Year Maximum Visits, each visit of up to 4 hours is one visit.

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 or your domestic partner's family.
- Services of a certified or licensed social worker.
- 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 Facility (GR-9N-11-060-01)
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 Using Your Medical Plan 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 11 070 ME)
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 and DME.
- Pain and symptom management;
- Nutritional counseling; and
- Counseling; Bereavement Services; and
- Respite Care

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 and DME;
  - **Pain and symptom management**;
  - Counseling;
  - Nutritional counseling.
  - Bereavement Services; and
  - Respite care

**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 ME)*

**Acupuncture**
The plan covers charges made for acupuncture services provided by a **physician** or a **licensed acupuncturist**, 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-ME)
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.

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

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

Autism Spectrum Disorders (GR-9N-11-171-01 ME)

Covered expenses include charges made by a physician or behavioral health provider for the services and supplies for the diagnosis and treatment, (including behavioral therapy and Applied Behavioral Analysis), of Autism Spectrum Disorder when ordered by a physician as part of a Treatment Plan; and

- The covered expenses are incurred for covered children who are 5 years of age or under.

Applied Behavioral Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
- Rett’s Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder—Not Otherwise Specified.
Coverage for Applied Behavioral Analysis for Autism Spectrum Disorders is subject to the maximum benefit amount, if any, shown on the Schedule of Benefits.

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

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

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

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

**Limitations**
The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the 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 Reminder**
Refer to the Schedule of Benefits for details about any **deductible**, **coinsurance** and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

**Outpatient Preoperative Testing**

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

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

**Limitations**
The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- 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.
Durable Medical and Surgical Equipment (DME) (GR-9N 11-090-01)

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.

Experimental or Investigational Treatment (GR 9N 14 095 ME)

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

- You have a life threatening illness for which no standard treatment is effective and you meet the clinical trials guidelines provided by Maine State Law.
- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
- The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
- You are treated in accordance with protocol.

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

**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 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 ME)**

**Covered expenses** include charges made for prosthetic devices. A prosthetic device is an artificial device meant to replace, in whole or in part, an arm or a leg.

Prosthetic devices are payable at no less than on the same basis as the most current standards of Medicare. The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of an arm or a leg lost or impaired as a result of disease or injury or congenital defects. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

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

- a prosthetic device that contains a microprocessor; or
- a prosthetic device that is designed exclusively for athletic purposes; or
- prosthetic services rendered by a provider who does not contract with Aetna and prosthetic devices provided by a vendor that is not designated by Aetna.

Prosthetic devices need to be precertified by Aetna. Refer to How the Plan Works for details about precertification.

**Prosthetic Devices other than artificial devices meant to replace, in whole or in part, an arm or a leg.**

In addition, **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 required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- Any item listed in the Exclusions section.

**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.

**Hearing Aid Expenses** *(GR-9N-11-110-02)*

**Covered expenses** include charges for the purchase of a hearing aid for each hearing-impaired ear for an individual who is under 19 years of age.
Hearing aid means a non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.

The hearing loss must be documented by a physician or audiologist licensed pursuant to Maine Title 32, chapter 77. The hearing aid must be purchased from an audiologist licensed pursuant to Maine Title 32, chapter 77 or a licensed hearing aid dealer licensed pursuant to Maine Title 32, Chapter 23-A.

Limitations:

- No benefits will be payable for a charge which is for batteries, cords and other assistive listening devices, including, but not limited to, frequency modulation systems.
- The maximum benefit payable is limited to $1,400 per hearing aid for each hearing-impaired ear every 36 months.

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 ME)

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 and Pulmonary Rehabilitation Benefits

- Cardiac rehabilitation benefits are available 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. The 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 must be initiated within 26 weeks after diagnosis of the above condition(s) and shall include physician-recommended continuance of Phase II rehabilitation services for up to 36 sessions in a hospital or community-based setting and up to 36 Phase III sessions in a community-based setting.

- Pulmonary rehabilitation benefits are available 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 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 delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down’s Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature. This does not apply to physical therapy, occupational therapy or speech therapy provided for treatment of Autism Spectrum Disorders.
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above;
- Services not performed by a physician or under the direct supervision of a physician;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- 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; or your domestic partner;
- 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 11-135-01-ME)

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

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

Outpatient Infusion Therapy Benefits
Covered expenses include infusion therapy received in 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. Some examples of infused medications covered under the pharmacy coverage are clotting factors for hemophilia (Advate, Novoseven, Alphanate, etc.), visco-supplements for osteoarthritis (Euflexxa, Orthovisc, Synvisc, etc.), ampicillin, ceftriaxone, cefazidime and gentamycin. 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 of this certificate.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are medically necessary for 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.

### Diabetic Equipment, Supplies and Education (GR-9N S-11-135-ME)

**Covered expenses** include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

• External insulin pumps;
• Blood glucose monitors without special features unless required due to blindness;
• Alcohol swabs;
• Glucagon emergency kits;
• Self-management training and education services that are provided through ambulatory diabetes education facilities authorized by the State’s Diabetes Control project within the Bureau of Health.
• Foot care to minimize the risk of infection.

### Treatment of Infertility (GR-9N 11-135-01-ME)

**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 and Advanced Reproductive Technology (ART) 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

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).

Advanced Reproductive Technology (ART) Benefits

ART is defined as:

- In vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery.

ART services for procedures that are covered expenses under this Booklet-Certificate.

Eligibility for ART Benefits

To be eligible for ART benefits under this Booklet-Certificate, you must meet the requirements above and:

- First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected;
- Be referred by your physician to Aetna's infertility case management unit;
- Obtain pre-authorization from Aetna's infertility case management unit for ART services by an ART specialist.

Covered ART Benefits

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the Exclusions and Limitations section of the Booklet-Certificate:

- Up to 3 cycles and subject to the maximum benefit, if any, shown in the Schedule of Benefits section of any combination of the following ART services per lifetime (where lifetime is defined to include all ART services received, provided or administered by Aetna or any affiliated company of Aetna) which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;
- IVF; Intra-cytoplasmic sperm injection (“ICSI”); ovum microsurgery; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit shown on the Schedule of Benefits section while covered under an Aetna plan;
- Payment for charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under this Booklet-Certificate.
Exclusions and Limitations
Unless otherwise specified above, the following charges will not be payable as covered expenses under this Booklet-Certificate:

- ART services for a female attempting to become pregnant who has not had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the infertility program;
- ART 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;

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.

Spinal Manipulation Treatment (GR-9N 11-150-01-ME)

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

Your benefits are subject to the maximum shown in the Schedule of Benefits. However, this maximum does not apply to expenses incurred:

- During your hospital stay; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating physician.
Metabolic Formula and Special Modified Low-Protein Food Products (GR-9N 5-11-135-ME)

Coverage shall include metabolic formula and special low-protein food products that have been prescribed by a licensed Physician to treat an inborn error of metabolism. An inborn error of metabolism means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. A special modified low-protein food product means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

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

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- 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).

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

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.
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 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 parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

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

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or 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 four phases of one 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; and
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.

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 network care expenses.

**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.

**Limitations**

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

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

Network of Transplant Specialist Facilities
Through the IOE network, you will have access to a provider network that specializes in transplants. Benefits may vary if an IOE facility or non-IOE or out-of-network provider is used. In addition, some expenses 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.

Obesity Treatment (GR-9N 11-165-01-ME)

Covered expenses include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:

• An initial medical history and physical exam;
• Diagnostic tests given or ordered during the first exam; and
• Prescription drugs.

Covered expenses include one morbid obesity surgical procedure, within a two-year period, beginning with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

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

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in this Booklet-Certificate.

Important Reminder
Refer to the Schedule of Benefits for information about any applicable benefit maximums that apply to morbid obesity treatment.

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

Treatment of Mental Disorders
Covered expenses include charges made for the treatment of mental disorders by behavioral health providers.

Important Note
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See Health Plan Exclusions and Limits for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

• There is a written treatment plan prescribed and supervised by a behavioral health provider;
• This Plan includes follow-up treatment; and
• This Plan is for a condition that can favorably be changed.
Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider’s office for the treatment of mental disorders as follows:

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

Important Reminder
Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.

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

Important Reminder
Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.

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

The plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Important Reminder
- Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.
- Please refer to the Schedule of Benefits for any copayments/deductibles, maximums, coinsurance limits or maximum out-of-pocket limits that may apply to your mental disorders benefits.

Treatment of Substance Abuse
Covered expenses include charges made for the treatment of substance abuse by behavioral health providers.

Important Note
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See Health Plan Exclusions and Limits for more information.

Substance Abuse
In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

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

Please refer to the Schedule of Benefits for any substance abuse deductibles, maximums, coinsurance limits or maximum out-of-pocket limits that may apply to your substance abuse benefits.
Inpatient Treatment
This Plan covers room and board at the semi-private room rate and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

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

Important Reminder
Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.

Outpatient Treatment
Outpatient treatment includes charges for treatment received for substance abuse while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

This Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Important Reminder
Inpatient treatment, partial-hospitalization care and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.

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

Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Important Reminders:

- Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.
- Please refer to the Schedule of Benefits for any copayments/deductibles, maximums, coinsurance limits or maximum out-of-pocket limits that may apply to your substance abuse benefits.

Amino Acid-Based Elemental Infant Formula
This Plan pays charges for amino acid-based elemental infant formula for children 2 years of age and under, regardless of the method of delivery of the formula, when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined under Maine law, that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed physician may be required to confirm and document ongoing medical necessity at least annually. Covered expenses will be payable the same as any other medical expense.

Such documentation includes when a licensed physician has diagnosed and through medical evaluation has documented one of the following conditions:
- Symptomatic allergic colitis or proctitis;
- Laboratory or biopsy-proven allergic or eosinophilic gastroenteritis;
- A history of anaphylaxis;
- Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
- Cystic, fibrosis; or
- Malabsorption of cow milk-based or soy milk-based infant formula

**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 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 28-015-07)**

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. 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.
**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 under the *What The Plan Covers* section for each of these benefits.

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. 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.

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

**Behavioral Health Services:**

- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet-Certificate.

Blood, blood plasma, except for **Emergency Care**, 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 are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge**, or 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, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons 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;
- 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);
- Removal of tattoos; and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.

Court ordered services, except for court-mandated substance abuse treatment, including those required as a condition of parole or release.

**Custodial Care**

Dental Services: 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, removal of bony impacted teeth, 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; and
- Non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

In addition, this exclusion does not apply to anesthesia or hospital services performed for an inpatient or outpatient dental procedure, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result; patients demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and patients who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

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:

- 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, except services related to contraception;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to 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;
- Injectable drugs if an alternative oral drug is available;
- Outpatient prescription drugs;
- Self-injectable prescription drugs and medications with the exception of contraceptives;
- Any prescription drugs, injectables, or medications or supplies provided by the policyholder or through a third party vendor contract with the policyholder; and
- Any expenses for prescription drugs, and supplies covered under an Aetna Pharmacy plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

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

Examinations:

- Any health examinations required:
  - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer 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; and

Any special medical reports not directly related to treatment except when provided as part of a covered service.

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the What the Plan Covers section.

**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 but not limited to infant formulas, nutritional supplements, vitamins, including but not limited to prescription vitamins, medical foods and other nutritional items, even if it is the sole source of
nutrition. This exclusion does not apply to Metabolic Formula and Special Modified Low Protein Food Products as specifically provided in the What the Plan Covers section.

Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- 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 but not limited to orthopedic shoes), foot 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.

Genetics: Any treatment, device, drug, service or supply to alter the body’s genes, genetic makeup, or the expression of the body’s genes except for the correction of congenital birth defects.

Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a stay in a hospital or other facility; and
- Any tests, appliances, and devices for the improvement of hearing (including but not limited to hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except otherwise provided under the What the Plan Covers section;
- Routine hearing exams except as covered under well child services.

Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as but not limited to:

- 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 but not limited to non-hospital electric and air 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 but not limited to 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 but not limited to 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 but not limited to 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.

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 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 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; 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 including:

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

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

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

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
Private duty nursing during your stay in a hospital, and outpatient private duty nursing services, except as specifically described in the Private Duty Nursing provision in the What the Plan Covers Section.

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

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

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

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

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

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

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

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

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

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

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

Transplant—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;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified by Aetna.

Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in What the Plan Covers section.

Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Aetna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Vision-related services and supplies, except as described in the What the Plan Covers section. The plan does not cover:

- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your stay in a hospital or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASK and similar procedures;
- Services to treat errors of refraction.
Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as provided by this Booklet-Certificate, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Work related: Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises 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-12-005-02)

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 Aetna 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.

A few important notes to consider before moving forward:

- Unless otherwise indicated, “you” refers to you and your covered dependents.
- Your prescription drug 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.

Notice

The plan does not cover all prescription drugs, medications and supplies. Refer to the Limitations section of this coverage and Exclusions section of your Booklet-Certificate.

- Covered expenses are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage and in your Schedule of Benefits.
- Injectable prescription drug refills will only be covered when obtained through Aetna’s specialty pharmacy network.

Getting Started: Common Terms (GR-9N-12-010-04 ME)

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.

Specialty Pharmacy Network. Aetna’s network of participating pharmacies designated to fill Self-injectable Drug prescriptions.

Accessing Pharmacies and Benefits (GR-9N-12-015-04 ME)
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.

Read your Schedule of Benefits carefully to understand the cost sharing charges applicable to you.

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

Accessing Network Pharmacies and Benefits (GR-9N-12-015-02 ME)
You may select a network pharmacy from the Aetna Network Pharmacy 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 network pharmacies. If you cannot locate a network pharmacy in your area call Member Services.

You must present your ID card to the network pharmacy every time you get a prescription filled to be eligible for network benefits. The network pharmacy will calculate your claim online. You will pay any deductible, copayment 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 benefits by filling your prescription at any network retail 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 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 be responsible for the copayment for each prescription or refill as specified in the Schedule of Benefits. The copayment will be the lesser of the copayment and the pharmacy's customary price of filling the prescription. The copayment is payable directly to the network pharmacy at the time the prescription is dispensed.

- After you pay the applicable copayment, you will be responsible for any applicable coinsurance for covered expenses that you incur. Your coinsurance amount is determined by the lesser of applying the applicable coinsurance percentage to the negotiated charge if the prescription is filled at a network pharmacy and such pharmacy’s customary price of filling the prescription. 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

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

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

- 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

What the Plan Covers

The plan covers charges for outpatient prescription drugs for the treatment of an illness or injury, subject to the Limitations section of this coverage 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. The preferred drug guide includes both brand-name prescription drugs and generic prescription drugs. Your out-of-pocket expenses may be higher if your physician prescribes a covered prescription drug not appearing on the preferred drug guide.
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 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.

Coverage for prescription drugs and supplies is limited to the supply limits as described below.

Pharmacy Benefits
Outpatient prescription drugs are covered when dispensed by a network or out-of-network retail pharmacy. Each prescription is limited to a maximum 30 day supply.

Prescription less than a 30 day supply or more than a 100 day supply are not eligible for coverage when dispensed by a network or out-of-network mail order pharmacy.

Other Covered Expenses
The following prescription drugs, medications and supplies are also covered expenses under this Coverage.

Off-Label Use
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 (the United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). 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 Aetna requirements or limitations.

Diabetic Supplies
The following diabetic supplies upon prescription by a physician:

- Insulin.
- Oral hypoglycemic agents.
- Glucose Monitors.
- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Contraceptives
The following contraceptives and contraceptive devices:

- Oral Contraceptives.
- Diaphragms, 1 per 365 consecutive day period
- Injectable contraceptives.
- Contraceptive patches.
- Contraceptive rings.
- Implantable contraceptives and IUDs are covered when obtained from a physician. The physician will provide insertion and removal of the drugs or device.
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.

Lifestyle/Performance Drugs

The following lifestyle/performance drugs:

- Sildenafil Citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Expenses include any prescription drug in oral or topical form that is similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.
- Coverage is limited to 6 pills or other form, determined cumulatively among all forms, for unit amounts as determined by Aetna to be similar in cost to oral forms, per 30 day supply. Mail order and 60 to 90 day supplies are not covered.

Pharmacy Benefit Limitations (GR-9N 13-015 01 ME)

A network 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.

You will be charged the out-of-network prescription drug cost sharing for prescription drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

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 the Booklet-Certificate.

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.

Pharmacy Benefit Exclusions (GR-9N 28-020 01 ME)

Not every health care service or supply is covered by the plan. Even if prescribed, recommended, or approved by your physician or dentist it may not be covered. 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:

- Administration or injection of any drug.
- Any charges in excess of the benefit, dollar, day, or supply limits stated in this Booklet-Certificate.
- Allergy sera and extracts.

Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Booklet-Certificate, or 2) such drugs or supplies
are unavailable or illegal in the United States, or 3) 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**.

Biological sera, blood, blood plasma, except for **Emergency Care**, blood products or substitutes or any other blood products.

**Contraception**: over the counter contraceptive supplies including but not limited to:
- condoms;
- contraceptive foams;
- jellies; and
- ointments;

**Cosmetic** drugs, medications or preparations used for cosmetic purposes or to promote hair growth, including but not limited to:
- health and beauty aids;
- chemical peels;
- dermabrasion;
- treatments;
- bleaching;
- creams;
- ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

Drugs given or entirely consumed at the time and place it is prescribed or dispensed.

Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy in oral, injectable and topical forms or any other form used internally or externally (including but not limited to gels, creams, ointments and patches). Any **prescription drug** in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes including but not limited to:

- Sildenafil citrate;
- Phentolamine;
- Apomorphine;
- Alprostadil; or
- Any other **prescription drug** that is in a similar or identical class; or has a similar or identical mode of action or exhibits similar or identical outcomes.

Drugs which do not, by federal or state law, need a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written.

Drugs given by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the **What the Plan Covers** section.

Drugs used for the purpose of weight gain or reduction, including but not limited to:
- stimulants;
Drugs used for the treatment of obesity.

**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 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. The one exception is for the correction of congenital birth defects.

Immunization or immunological agents.

Implantable drugs and associated devices.

**Injectables**:

- Any charges for the administration or injection of *prescription drugs* or injectable insulin and other injectable drugs covered by *Aetna* with the exception of contraceptives;
- Needles and syringes, except for diabetic needles and syringes;
- Injectable drugs if an alternative oral drug is available.

**Prescription drugs**, medications, injectables or supplies given through a third party vendor contract with the policyholder.

**Prescription** orders filled prior to the effective date or after the termination date of coverage under this Booklet-Certificate.

Prophylactic drugs for travel.

Refills over the amount specified by the *prescription* order. Before recognizing charges, *Aetna* may require a new *prescription* or proof 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 allowed by applicable law of the jurisdiction in which the drug is dispensed.
Replacement of lost or stolen prescriptions.

Drugs, services and supplies given in connection with treatment of an occupational injury or occupational illness.

Strength and performance: Drugs or preparations, devices or supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

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-30-005-05 ME)*

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** *(GR-9N-30-005-05 ME)*

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 the purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not at work due to disease or injury, your employment may be continued until stopped by your employer, but not beyond 30 months from the start of the absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day of active 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)*

Under the Health Insurance Portability and Accountability Act of 1996, your employer is required to give you a certificate of creditable coverage when your employment ends. This certificate proves that you were covered under this plan 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 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.

In addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership. In that event, you should provide your Employer a completed and signed Declaration of Termination of Domestic Partnership.

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-31-010-03)

**Continuing Health Care Benefits** (GR-9N-31-015-06)

**Continuing Coverage**

If you:

- terminate employment due to a temporary lay-off; or
- lose employment due to an **injury** or disease that you claim to be compensable under workers' compensation;

You may continue any Health Expense Coverage (except Comprehensive Dental Expense Coverage) then in force if:

- you have been employed by your employer for at least 6 months;
- you are not eligible for Medicare;
- you are not covered for like benefits;
- you are not eligible for like benefits under any group plan;
- you are not eligible for continuation of like benefits because of any state or federal law; and
- premium payments are continued.

The coverage may be continued for you or any of your dependents who have been covered as your dependent for at least 3 months or for you and any such dependents. If a dependent has not been eligible for 3 months, the dependent must have been covered at all times while eligible.

You have to make request in writing for this continuation. This must be done within 31 days of the date coverage would otherwise cease. The request must include an agreement to pay up to 102% of the applicable group rate.

Coverage will cease on the first to occur of:

- The date you are eligible for coverage under any other group plan.
- The date you fail to make the contributions needed.
- The date the Workers' Compensation Commission determines that the disease or **injury**, that entitled the person to continued coverage, is not compensable.
- The end of a one year period which starts on the date coverage would otherwise cease.

Coverage of a dependent will cease earlier when the dependent ceases to be a defined dependent.

If any coverage being continued ceases because it has been continued for one year, the person may apply for a personal policy in accordance with the Conversion Privilege. If it ceases for any other reason, the Conversion Privilege is not available.
Continuing Coverage for Dependents After Your Death
If you should die while enrolled in this plan, your dependent’s health care coverage will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the When Coverage Ends section;
- A request is made for continued coverage within 31 days after your death; and
- Payment is made for the coverage.

Your dependent’s coverage will end when the first of the following occurs:

- The end of the 12 month period following your death;
- He or she no longer meets the plan’s definition of “dependent”;
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

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

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, Converting to an Individual Medical Insurance Policy for more information.

Continuing Coverage for Dependent Students on Medical Leave of Absence
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 ME)
Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children 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 31 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.

Extension of Benefits (GR-9N 31-020 01 ME)

Coverage for Health Benefits
If your health benefits end while you are totally disabled, your health expenses will be extended as described below.
To find out why and when your coverage may end, please refer to When Coverage Ends.

The words “totally disabled” mean:

- For a person who was gainfully employed before the disability started:
  - That due to injury or disease, the person is not able to engage in any gainful job for which he or she is reasonably suited by:
    - training; or
    - education; or
    - experience.
- For any other person:
  - That due to injury or disease, the person is not able to engage in most of the normal activities of a person of like age in good health.
Extended Health Coverage (GR-9N 31-020-01 ME)

Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, 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

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.

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<td>Duration</td>
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<tr>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>You divorce or legally separate and are no longer responsible for dependent coverage</td>
<td>Your dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>You become entitled to benefits under Medicare</td>
<td>Your dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>Your covered dependent children no longer qualify as dependents under the plan</td>
<td>Your dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>You die</td>
<td>Your dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>You are a retiree eligible for health coverage and your former employer files for bankruptcy</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
</tbody>
</table>

**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 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent 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.

Conversion from a Group to an Individual Plan
You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment.
- When loss of coverage under the group plan occurs.
- When loss of dependent status occurs.
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by your employer. Certain benefits may not be available. You will be required to pay the associated premium costs for the coverage. For additional conversion information, contact your employer or call the toll-free number on your member ID card.

Converting to an Individual Medical Insurance Policy (GR-9N 31-040 01 ME)
This applies if you reside in a state other than Maine. The state where you legally reside may mandate that a personal policy be offered for conversion when Medical Expense Coverage ends, no matter where the group policy may have been issued. In this case, this plan will permit certain persons whose Medical Expense Coverage has ended to convert to a personal medical policy. No medical exam is needed. You and your family members may convert when all coverage ends because:

- of the end of your employment; or
- you cease to be in an eligible class.

But, you and your family members may not convert if coverage ends because the group contract has been discontinued as to your medical coverage.

The personal policy may cover you only.

You may convert when you become a retired employee. If this plan permits retired employees to continue Medical Expense Coverage, and you choose to do so, this conversion privilege will not again be available to you.

The personal policy must be applied for within 31 days after coverage ceases or would otherwise cease without a provision to continue coverage for retired employees. The 31 days start on the date coverage ceases even if the person is still eligible for benefits because the person is totally disabled.
Aetna may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:
  - any other hospital or surgical expense insurance policy;
  - any hospital service or medical expense indemnity corporation subscriber contract;
  - any other group contract;
  - any statute, welfare plan or program;
- and that with the converted policy, would result in over insurance or match benefits.
- The state where you legally reside does not require conversion if the person is or could be covered under Medicare (Title XVIII of the Social Security Act, as amended).

No one has the right to convert if:

- he or she has used up the maximum benefit; or
- he or she becomes eligible for any other Medical Expense Coverage under this plan.

The personal policy form, and its terms, will be of a type, for group conversion purposes:

- as required by law or regulation; or
- as then offered by Aetna under your employer’s conversion plan.

It will not provide coverage which is the same as coverage under this plan. The level of coverage may be less and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both of:

- A statement that benefits under it will be cut back by any like benefits payable under this plan after your coverage ceases.
- A statement that Aetna may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.

The personal policy will state that Aetna has the right to refuse renewal under some conditions. These will be shown in that policy.

If you want to convert:

- Your employer should be asked for a copy of the "Notice of Conversion Privilege and Request" form.
- Send the completed form to the address shown.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply.

The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be Aetna's normal rate for the person's class and age, and the form and amount of coverage.

The personal policy will take effect on the day after coverage terminates under this plan.
Coordination of Benefits - What Happens When There is More Than One Health Plan

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. “Plan” and “This plan” are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Plans covering a person are high deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan’s deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan’s payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.
When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

**Closed Panel Plan(s).** A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

**Custodial Parent.** A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

**Plan.** Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the policy that provides benefits for health care expenses.

**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.
Which Plan Pays First (GR-9N-33-010-01)

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, 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); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      i. The parents are married or living together whether or not married;
      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   B. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent’s spouse does, the plan of the parent’s spouse is the primary plan.
   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
      – The plan of the custodial parent;
      – The plan of the spouse of the custodial parent;
      – The plan of the noncustodial parent; and then
      – The plan of the spouse of the noncustodial parent.

   For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. 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 rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, or subscriber longer is primary.

6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

**How Coordination of Benefits Works** *(GR-9N-33-015-02 ME)*

When this plan is secondary, it may reduce its benefits so that total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of This Plan, the amount normally reimbursed for covered benefits or expenses under This Plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under This Plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of This Plan and another plan both agree that This Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

**Credit Toward Deductible of Secondary Plan**

When you or your dependent is covered under more than on expense-incurred medical plan, expenses for eligible benefits covered under the secondary plan shall be credited toward the deductible of the secondary plan for any:

- payments made by the primary plan;
- payments made by you;
- and payments made from a health savings account, or similar fund.

This section does not apply if the secondary plan is supplemental to the primary plan.

**Right To Receive And Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

**Facility of Payment**

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, 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” 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; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.
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.

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-S-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-ME)

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

The following information does not apply to Life Insurance.

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

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 32-005-01 ME)

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.

Subrogation and Right of Reimbursement (GR-9N 32-010-01 ME)

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.

By providing written notice, 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 on a fair and equitable basis 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 providing written notice, you also specifically acknowledge Aetna’s right of reimbursement. This right of reimbursement shall be done on a fair and equitable basis. 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.

For the basis of these subrogation and reimbursement provisions, a just and equitable basis shall be defined as any factors that diminish the potential value of your claim shall likewise reduce the share in the claim Aetna shall receive in recompensation for benefits paid.

These factors that may diminish the potential value of your claim shall include, but are not limited to the following:

1. legal defenses;
2. exigencies of trial; and/or
3. limits of coverage.

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; s
- 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 ME)

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 (GR-9N-32.020.01 ME) (GR-9N-32.015.01 ME)

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 physician provides care for you or a covered dependent, or care is provided by a network provider on referral by your physician (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 ME)*

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.*
Incentives (GR.9N 32.045.01)

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your physician or other service providers, we may, from time to time, offer to waive or reduce a member’s copayment, coinsurance, and/or a deductible otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.
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 34-005-03 ME)*

**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 01 ME)*

**Behavioral Health Provider/Practitioner**

A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

**Birthing Center**

A freestanding facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- 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.

Coinurance
Coinurance 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.

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.

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.

Day Care Treatment
A partial confinement treatment program to provide treatment for you during the day. The hospital, psychiatric hospital or residential treatment facility does not make a room charge for day care treatment. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

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

Dentist
A legally qualified dentist, or a physician licensed to do the dental work he or she performs.

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.

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**E (GR.9N 34-025 02)**

**E-visit**
An **E-visit** is an online internet consultation between a **physician** and an established patient about a non-emergency healthcare matter. This visit must be conducted through an **Aetna** authorized internet E-visit service vendor.

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

**Emergency Medical Condition**
A recent and severe medical condition, including (but not limited to) severe pain, or in the case of a pregnant woman who is having contractions, for which there is inadequate time to transfer her to another hospital for delivery, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

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

**Experimental or Investigational**
Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the 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.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
that 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 inpatient care in a hospital or skilled nursing facility (This facility is defined in Title XVIII of the Social Security Act).

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;
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management;
  - Medical supplies and DME;
  - Nutritional counseling;
  - Counseling; and
  - Bereavement Services.
- 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

Jaw Joint Disorder

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

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

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. The maximum out-of-pocket limit applies to both network and out-of-network out-of-pocket expenses.

The following expenses do not apply toward your maximum out-of-pocket limits:

- 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.
Medically Necessary or Medical Necessity
These are health care or dental services, and supplies or prescription drugs 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
An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist or a psychiatric social worker.

Any one of the following conditions is a mental disorder under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizoaffective disorder.
- Schizophrenia.

Also included is any other mental condition which requires Medically Necessary treatment.

Morbid Obesity
This means a Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.
Negotiated Charge
As to health expense coverage, other than Prescription Drug Expense Coverage:

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

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

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.

**Occupational Injury or Occupational Illness**

An injury or illness that:

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

**Occurrence**

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

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

**Orthodontic Treatment**

This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.
The following are not considered **orthodontic treatment**:

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

**Other Health Care**

A health care service or supply that is neither network service(s) or supply(ies) nor out-of-network service(s) and supply(ies). **Other health care** can include care given by a provider who does not fall into any of the categories in your provider directory (or in DocFind at Aetna's website).

**Out-of-Network Service(s) and Supply(ies)** *(GR-9N-34-075-01 ME)*

Health care service or supply that is:

- Furnished by an out-of network provider; or
- Not other health care.

**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.

**Partial Confinement Treatment** *(GR-9N-34-080-05 ME)*

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

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

**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, a mental disorder or a biologically-based mental conditions; and
A physician is not you or related to you.

Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician. These include, but may not be limited to the following:

- Acupuncturist;
- Chiropractor;
- Optometrist;
- Certified Registered Nurse Anesthetists;
- Certified Nurse Midwives;
- Certified Nurse practitioner;
- Registered Nurse First Assistant.

**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.

**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.

**Psychiatric Hospital**
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, mental disorders or biologically-based mental illnesses.
- 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, mental disorders or biologically-based mental illnesses.

**R**

**Recognized Charge**
The covered expense is only that part of a charge which is the recognized charge.

As to medical, vision and hearing expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  - 105% of the Medicare Allowable Rate; for the Geographic Area where the service is furnished.
- For inpatient and outpatient charges of hospitals and other facilities:
  - 140% of the Medicare Allowable Rate; for the Geographic Area where the service is furnished.

As to prescription drug expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- 110% of the Average Wholesale Price (AWP) or other similar resource. 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).
A service or supply will be treated as a **covered expense** under the Other Health Care benefits category when Aetna determines that a **network** provider is not available to provide the service or supply. This includes situations in which you are admitted to a **network hospital** and non-**network physicians**, who provide services to you during your **stay**, bill you separately from the **network hospital**. In those instances, the **recognized charge** for that service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services:
  - 105% of the Medicare Allowable Rate;
  - for the Geographic Area where the service is furnished.
- For facility charges:
  - 140% of the Medicare Allowable Rate;
  - for the Geographic Area where the service is furnished.

If Aetna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

**Aetna** may also reduce the **recognized charge** by applying **Aetna Reimbursement Policies**. **Aetna Reimbursement Policies** address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- 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.

**Aetna Reimbursement Policies** are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and dentists practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Medicare Allowable Rates are defined as follows:

- **Geographic Area**: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- **Medicare Allowable Rates**: These are the rates established and periodically updated by The Centers for Medicare and Medicaid Services (CMS) for payment for services and supplies provided to Medicare enrollees. **Aetna** updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate for a particular service, the rate will be based on the same method that CMS uses to set Medicare rates.

**Important Note**

**Aetna** periodically updates its systems with changes made to the Medicare Allowable Rates. **What this means to you** is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.
Additional Information
Aetna’s website 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, or contact our Customer Service Department for assistance.

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)
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 or any such related or similar program, school and/or education service.

Residential Treatment Facility (Substance Abuse)
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.
- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7 days a week, which must be actively supervised by an attending Physician.
- 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 or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.
- On-site, licensed **Behavioral Health Provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

**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 34-095-05)*

**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. An updated copy of the list of self-injectable drugs designated by this plan to be refilled by or obtained through the specialty pharmacy network is available upon request or may be accessed at the **Aetna** website as www.aetna.com. The list is subject to change by **Aetna**.

**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, as defined in Title XVIII of the Social Security Act, and that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  - Professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**.
- Is supervised full-time by a **physician** or an **R.N.**.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders or biologically-based mental illnesses.
- 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, mental disorders or biologically-based mental illnesses.

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
Prescription drugs include injectable, infusion and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis which are listed in the specialty care drug list.

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.

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

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

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- 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.

T (GR-9N-34-100-02-ME)

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)

**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 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.
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
Hartford, Connecticut 06156

Amendment (GR-Grp/AppealsER-03)
Policyholder: President And Trustees Of Bates College
Group Policy No.: GP-869807
Rider: Maine Appeals Procedure and External Review
Issue Date: June 16, 2015
Effective Date: This Booklet-Certificate Amendment is effective on January 1, 2015

The group policy noted above has been amended. The following summarizes the changes in the group policy and the Booklet-Certificate, describing the policy terms, is amended accordingly. This amendment is effective on the date shown above.

The following Appeals Procedure, Exhaustion of Process and External Review provisions replace the same provisions appearing in your Booklet-Certificate or any amendment or rider issued to you:

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision): 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.
- Coverage determinations, including Plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is experimental or investigational.
- A decision that the service or supply is not medically necessary.

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.

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.

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.

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

Retrospective 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

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 48 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.

Pre-Service Claims

Aetna will notify you of a pre-service claim decision for non-urgent services after the claim is made as soon as possible, but not later than 2 working days after obtaining all necessary information. Aetna will not later render an adverse decision with respect to any pre-authorized services except if fraudulent or materially incorrect information was provided at the time the services were pre-authorized, and such information was used in pre-authorizing the service.
Retrospective Claims

Aetna will notify you of a retrospective claim decision after the claim is made as soon as possible, but not later than 30 calendar days after obtaining all necessary information.

Concurrent Care Claim Extension

Following a request for a concurrent care claim extension, Aetna will notify you of a claim decision within one working day after obtaining all necessary information.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment within one working day after obtaining all necessary information.

As to medical and prescription drug claims only, if you file an appeal, coverage under the plan will continue for the previously approved 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. 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.

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 or two levels of appeal depending upon the type of coverage provided under the Plan. As to medical and prescription drug claims only, a final adverse benefit determination notice will also provide an option to request an External Review.

You have 180 calendar days with respect to adverse benefit determinations of Group Health Claims following the receipt of notice of an adverse benefit determination to request your Level One Appeal. Your appeal may be submitted orally or 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, or call in your appeal to Member Services using the telephone number listed on the notice.

You may also choose to have another person (an authorized representative) make the appeal on your behalf. You must provide written consent to Aetna.
As to medical and prescription drug claims only, 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 – Adverse Benefit Determination (Group Health Claims)**

A review of a Level One Appeal of an adverse benefit determination shall be provided by Aetna personnel. They shall not have been involved in making the adverse benefit determination. Except for Urgent Care Claims, an acknowledgement letter will be sent to you within three (3) working days of Aetna's receipt of the appeal. The letter will contain the name; address; and telephone number of the Appeal Coordinator assigned to review the appeal. If the appeal concerns medical necessity; appropriateness; health care setting; level of care; or effectiveness the Coordinator will be a clinical peer health care professional. If the letter requests additional information, it must be sent to Aetna within the next 15 days.

**Urgent Care Claims**

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

**Pre-Service Claims**

Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal or receipt of any additional information requested.

**Concurrent Care Claim Reduction or Termination**

Aetna shall issue a decision within one working day of the request for an appeal or receipt of any additional information requested.

**Retrospective Claims**

Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal or receipt of any additional information requested. Aetna will notify you in writing within 5 working days after making the determination.

If Aetna's final decision is an adverse decision, it will contain:

- The names; titles; and qualifying credentials of the person(s) involved in the review;
- A statement of the Committee's understanding of the Appeal; and all pertinent facts;
- The specific plan provisions upon which the decision is based;
- The Committee's basis for the decision in clear terms;
- A reference to the evidence; or documentation; used as the basis for the decision; and instructions for requesting copies of such materials;
- A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number of the Bureau;
- A description of the process to obtain a level two Appeal (including the rights; procedures; and time frames that govern such an appeal).
- The availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act;
- Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process;
- Any other information required pursuant to the federal Affordable Care Act.

**Level Two Appeal - Adverse Benefit Determination (Group Health Claims)**

If Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative has the right to file a level two appeal. The appeal must be submitted following the receipt of notice of a level one Appeal.
A level two Appeal of an decision involving an Urgent Care Claim, or a claim involving medical necessity; appropriateness; health care setting; level of care; or effectiveness; shall be provided by the Aetna Appeals Committee. The majority of the Committee will be made up of persons not previously involved in the Appeal. However, a person who was previously involved in the Appeal may be a member of the Committee. Such person may also appear before the Committee to present information or answer questions. The Committee must include one or more clinical peer health care professionals who were not previously involved in the Appeal, who are not a subordinate of a person involved in the Appeal, and who have no financial or other personal interest in the outcome of the review. The level two Appeal decision must have the concurrence of the majority of such clinical peer health care professionals.

For a level two Appeal concerning all other appeals, the majority of the Committee will be made up of employees or representatives of Aetna who were not previously involved with the Appeal. However, a person who was previously involved in the Appeal may be a member of the Committee. The person may also appear before the Committee to present information; or answer questions.

If you ask to appear in person before the Committee, the Committee will notify you in writing 15 days in advance of the hearing date. The notice will also advise you if an attorney will be present to argue Aetna’s case against you. Aetna will also advise you of your right to obtain legal representation. The hearing will be held during regular business hours. If you cannot attend the hearing, you may participate by conference call; or other available technology; at Aetna’s expense. You may also request that Aetna consider a postponement and rescheduling of the hearing. In addition:

- You may request Aetna to provide you with all relevant information that is not confidential or privileged.
- You may be helped or represented at the hearing by the person of your choice.
- You may submit supporting material. This may be done both before and during the hearing.
- You may ask questions of any Aetna representative.

**Urgent Care Claims**
Aetna shall issue a decision within 36 hours of receipt of the request for a level two Appeal.

**Pre-Service Claims**
Aetna shall issue a decision within 15 calendar days of receipt of the request for a level two Appeal.

**Concurrent Care Claim Reduction or Termination**
Aetna shall issue a decision within one working day of the request for an appeal or receipt of any additional information requested.

**Retrospective Claims**
Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two Appeal.

If the decision is an adverse decision, it will contain:

- The names; titles; and qualifying credentials of the person(s) involved in the level one Appeal review;
- A statement of the Committee's understanding of the Appeal and all pertinent facts;
- The Committee's basis for the decision in clear terms;
- A reference to the evidence; or documentation; used as the basis for the decision; and instructions for requesting copies of such materials; and
- A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number of the Bureau.

Aetna will keep the records of your complaint for 3 years.
NOTICE:

You may contact the Maine Bureau of Insurance at any time during the Appeal Process outlined above. The address is:

Maine Bureau of Insurance  
Consumer Health Care Division  
34 State House Station  
Augusta, Maine 04333  
Telephone Number: 1-800-300-5000  
Web: www.state.me.us/pfr/ins/ins_index.htm

Exhaustion of Process

You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you can 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.

As to medical and prescription drug claims only, 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:

As to medical and prescription drug claims only, if Aetna does not adhere to all adverse benefit determination and appeal requirements (including required timeframes for issuing decisions) of the State of Maine and 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 an 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.

External Review

If Aetna renders a decision resulting in an Adverse Benefit Determination you may contact the Maine Bureau of Insurance to request an external review; if you or your provider disagrees with Aetna’s decision. An external review is a review by an independent external review organization, who has expertise in the problem or question involved. The Maine Bureau of Insurance oversees the external review process. It also contracts with approved independent review organizations to carry out the external review and render a decision.
To request an **External Review**, any of the following requirements must be met:

- You have received notice of the denial of a claim by an Adverse Benefit Determination from Aetna; and
- Your claim was denied because Aetna determined that the care was not **medically necessary** or was **experimental or investigational**; and
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal **appeal** processes.

The **adverse benefit determination** you receive from Aetna will describe:

- the external review process and the procedure to follow if you wish to pursue an external review;
- your right to get assistance from Aetna to request the external review;
- your right to attend the external review; submit; and obtain supporting material relating to the adverse decision; ask questions of any Aetna representative; and have outside assistance; and
- your right to seek assistance from; or file a complaint with; the Maine Bureau of Insurance (including the Bureau's address and toll-free number).

You or your authorized representative must send the request for external review in writing to the Maine Bureau of Insurance. The request must be made within 12 months of the date you received the final adverse decision letter from Aetna. You also must include: a copy of the final adverse decision letter; and all other pertinent information that supports your request. You will not be required to pay any fees.

**Expedited request for external review:** You will not be required to exhaust the applicable internal Appeals process before requesting an external review if:

- Aetna has failed to make a decision within the required time period; or
- You and Aetna agree to bypass the internal Appeals procedure; or
- Your life or health is in serious jeopardy; or
- You have died.

The Maine Bureau of Insurance will contact the external review organization that will conduct the review of your claim. The external review organization will select an independent **physician** with appropriate expertise to perform the review. In making a decision, the external review organization will consider how appropriate the service is based on:

- All relevant clinical information relating to your physical and mental condition;
- Any concerns you have voiced about your health status; and
- All relevant clinical standards, including but not limited to, those standards and guidelines used by Aetna.

You will be notified of the decision of the external review organization within 30 calendar days of receipt of your request form and all necessary information from the Maine Bureau of Insurance. If your condition is such that a delay would put in serious jeopardy your life or health or your ability to regain maximum function, a decision will be made no later than 72 hours after receipt of the request.

Aetna will abide by the decision of the External Review Organization. Aetna is responsible for paying the Maine Bureau of Insurance for the cost of the external review.

For more information about the Appeals Procedure or **External Review** processes, call the **Member Services** telephone number shown on your ID card.

This amendment makes no other changes to the Group Policy or the Booklet-Certificate.
Mark T. Bertolini
Chairman, Chief Executive Officer, and President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Appeals
Issue Date: June 16, 2015
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), third party administrators, and 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

President and Trustees of Bates College

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:
President and Trustees of Bates College

Employer Identification Number:
01-0211781

Plan Number:
526

Type of Plan:
Health and Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

President and Trustees of Bates College
215 College Street
Lewiston, ME 04240
Telephone Number: (207) 786-8271

Agent For Service of Legal Process:

President and Trustees of Bates College
215 College Street
Lewiston, ME 04240
Service of legal process may also be made upon the Plan Administrator

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 the Person designated by the Plan Administrator.

**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

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.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Patient Protection and Affordable Care Act (PPACA) 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 PPACA.

The following is a summary of the requirements under PPACA.

1. For non-grandfathered plans:
   a. Subject to any applicable age, family history and frequency guidelines, the following preventive services, to the extent they are not already, are covered under the plan at the Preferred Care level benefits only. Preventive services will be paid at 100% per visit and without cost-sharing such as payment percentages; copays; deductibles; and dollar maximum benefits:
      - Items or services with an “A” or “B” rating from the United States Preventive Services Task Force;
      - Immunizations pursuant to the Advisory Committee on Immunization Practices (“ACIP”) recommendations; and
      - Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”).
   b. If the plan requires or recommends that you designate a primary care provider, you may select any participating primary care provider who is available to accept you. In addition, you may select any participating pediatrician as your child’s primary care provider, if the provider is available to accept your child.
   c. If your plan requires the referral or authorization from the primary care provider before receiving obstetrical or gynecological care from a participating provider who specializes in obstetrics or gynecological care, this requirement no longer applies. Care includes the ordering of related obstetrical and gynecological items and services that are covered under your plan.
   d. You do not need prior authorization for the treatment of an emergency medical condition, even if the services are provided by a non-participating provider. Care provided by a non-participating provider will be paid at no greater cost to you than if the services were performed by a participating provider. You may receive a bill for the difference between the amount billed by the provider and the amount paid by Aetna. If a non-participating provider bills you directly for an amount beyond your cost share for the treatment of an emergency medical condition, you are not responsible for paying that amount. Please send the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over the amount. Make sure your member ID number is on the bill.
   e. You have the right to appeal any action taken by Aetna to deny, reduce or terminate the provision or payment of health care services. When we have done this based on the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service, you have the right to have the decision reviewed by an external review organization.
2. For grandfathered and non-grandfathered plans:
   a. Any overall plan calendar year and lifetime dollar maximums no longer apply.

   b. Any calendar year or annual and lifetime dollar maximum benefit that applies to an "Essential Service" (as required by PPACA and defined by Aetna) for Preferred Care and Non-Preferred Care no longer applies. Essential Services 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.

   c. If your Plan includes a pre-existing condition limitation provision, including one that may apply to transplant coverage, then this provision will not apply to a person under 19 years of age.

   d. The eligibility rules for children have been changed. A child will now be eligible to enroll if he or she is under 26 years of age. Any rule that they be a full-time student, not married or solely dependent upon you for support will not apply. **Please Note:** For grandfathered plans only, if your child (under age 26) is eligible for employer based coverage other than through a parent’s plan, then that child may not be eligible to enroll in this Plan. Contact your policyholder for further information.

   e. If your coverage under the Policy is rescinded, Aetna will provide you with a 30 day advance written notice prior to the date of the rescission.
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:
     - 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](http://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. The medical in-network out-of-pocket maximum for a plan that does use a provider network, and the out-of-pocket maximums for a plan that does not use a provider network - cannot exceed $6,350 per person and $12,700 per family for your 2014 plan year. If your medical plan is packaged with a plan that covers outpatient prescription drugs, the outpatient prescription drug plan may:
   a. not include out-of-pocket maximums; or
   b. have separate maximums from the medical plan up to these same amounts; or
   c. have maximums that are combined with the medical plan up to these same amounts.

3. 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.

4. 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.

5. 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 FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.
BENEFIT PLAN

Prepared Exclusively for
President and Trustees of Bates College

Medical ET Riders

Aetna Life Insurance Company

These Extraterritorial Riders are part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder
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Massachusetts Mental Health Parity Laws and the Federal Mental Health Parity and Addiction Equity Act (MHPAEA)

This notice is sent to give you information about your benefits for mental health and substance use disorder services. Under both Massachusetts laws and federal laws, benefits for mental health services and substance use disorder services must be comparable to benefits for medical/surgical services. This means that copays, coinsurance and deductibles, for mental health and substance use disorder services must be at the same level as those for medical/surgical services. Also, our review and authorization of mental health or substance use disorder services must be handled in a way that is comparable to the review and authorization of medical/surgical services.

If we make a decision to deny or reduce authorization of a service, we will send you a letter explaining the reason for the denial or reduction. We will send you or your provider a copy of the criteria used to make this decision, at your request.

If you think that we are not handling your benefits for mental health and substance use disorder services in the same way as for medical/surgical services, you may file a complaint with the Division of Insurance (DOI) Consumer Services Section.

You may file a written complaint using the DOI’s Insurance Complaint Form. You may request the form by phone or by mail or find it on the DOI’s webpage at:

http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html

You may also submit a complaint by phone by calling 877-563-4467 or 617-521-7794. If you submit a complaint by phone, you must follow up in writing and include your name and address, the nature of your complaint and your signature authorizing the release of any information.

Filing a written complaint with the DOI is not the same as filing an appeal under your plan. You must also file an appeal with us in order to have a denial or reduction in coverage of a service reviewed. This may be necessary to protect your right to continued coverage of treatment while you wait for an appeal decision. Follow the appeal procedures outlined in your plan for more information about filing an appeal.
Aetna Life Insurance Company  
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)  
Policyholder: President And Trustees Of Bates College  
Group Policy No.: GP-869807  
Rider: Massachusetts ET Medical - OC PPO  
Issue Date: June 16, 2015  
Effective Date: January 1, 2015

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Massachusetts. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits.** You are only entitled to these benefits, if you are a resident of Massachusetts, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Physician Profiling

Physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

Interpreter and Translation Services

You may contact Member Services at the toll-free telephone number listed on your I.D. card to receive information on interpreter and translation services related to administrative procedures. A TDD# for the hearing impaired is also available.

French  
**Services d'interprétation et de traduction**  
Vous pouvez contacter les services aux membres au numéro de téléphone sans frais indiqué sur votre carte d'identification pour recevoir de l'information sur les services d'interprétation et de traduction se rapportant aux procédures administratives. Les professionnels du service à la clientèle Aetna ont accès à des services de traduction par le biais des services linguistiques téléphoniques de AT&T. Un numéro de téléphone ATME est aussi disponible pour les malentendants.
In no event will the covered amount for In-Network charges exceed more than 20% of the covered amount for Out-of-Network charges.
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, or whose parent is your child and is covered as a dependent under the plan.

**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. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent’s life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, 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.

If you fail to make an application to obtain coverage of a child, Aetna shall enroll such child upon application by such child’s other parent, by the division of medical assistance or upon receipt of a national medical support notice from the IVD agency.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing 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 or QDRSO, 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.

**Prosthetic Devices**

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;
- A durable brace that is custom made for and fitted for you;
- A scalp hair prosthesis (wig) for hair loss due to treatment of any form of cancer or leukemia;
- Therapeutic/molded shoes and shoe inserts required for the treatment of or to prevent complications of diabetes.

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

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items or
- any item listed in the Exclusions section.

PPO Medical Plan (GR-9N-S10-80-01 MA)

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
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<tbody>
<tr>
<td>Prosthetic Devices</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
</tbody>
</table>

Any coinsurance requirement for artificial limb devices to replace, in whole or in part, an arm or leg will not exceed 20%, unless such coinsurance applies to all covered benefits. With respect to Out of Network charges, any coinsurance will not exceed 40% of the cost unless such coinsurance applies to all covered benefits under the plan.

<table>
<thead>
<tr>
<th>Scalp Hair Prosthesis for Cancer or Leukemia Patients (GR-9N-S10-95-01 MA)</th>
<th>Payable in accordance with the type of expense incurred and the place where service is provided.</th>
<th>Payable in accordance with the type of expense incurred and the place where service is provided.</th>
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<tbody>
<tr>
<td>Maximum Benefit per Calendar Year</td>
<td>$350</td>
<td>$350</td>
</tr>
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</table>

Cleft Lip or Palate Treatment
Treatment of Cleft Lip or Palate of Dependent Children Under Age 18

Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Medical, dental, oral surgery and facial surgery, surgical management including pre- and post-operative care provided by oral and plastic surgeons;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Preventative and restorative dentistry to ensure good health;
- Adequate dental structures for orthodontic treatment or prosthetic management therapy;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiology;
- Nutrition services;
- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

If such services are prescribed by the treating physician or surgeon and such physician or surgeon certifies that such services are medically necessary and consequent to the treatment of the cleft lip, cleft palate or both.

Payment for dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate will not be covered under this section.

**Limitations**

Unless specified above, not covered under this benefit are:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

**Hearing Aids Expense**

**Covered expenses** include charges incurred by a covered person for the cost of one hearing aid per hearing impaired ear every 36 months upon written statement from the covered person’s treating physician that the hearing aid(s) are necessary regardless of etiology.

**Covered expenses** also include related services prescribed by a licensed audiologist or hearing instrument specialist, including the initial hearing aid evaluation, fitting and adjustments and supplies, including ear molds.

Coverage is provided under the same terms and conditions as for any other condition.

<table>
<thead>
<tr>
<th>Hearing Aids (GR-9N.3-36-30-05 MA)</th>
<th>100% per item after Calendar Year deductible</th>
<th>100% per item after Calendar Year deductible</th>
</tr>
</thead>
</table>

**Clinical Trial Expenses** *(GR-9N 11-210-01 MA)*

This Plan will pay for **medically necessary** and routine patient care, **physician**, and facility charges you incur when enrolled in a qualified clinical trial study.
A "qualified clinical trial" means a patient research study that meets the following criteria:

- it must be intended to treat cancer; and
- it must be peer reviewed and approved by one of the following:
  - one of the United States Institutes of Health;
  - a center or cooperative group of the National Institutes of Health;
  - a qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
  - the Food and Drug Administration (FDA) pursuant to an investigational new drug exemption;
  - the Department of Defense;
  - the Department of Veterans Affairs; or
- with respect to a Phase II, III and IV clinical trial
  - a qualified institutional review board; and
  - it must be provided by a provider of health care which has the experience and training to provide the treatment in a capable manner; and
- with respect to Phase I clinical trials
  - it must be provided by an academic medical center or affiliated facility, and the providers conducting the trial shall have staff privileges at the academic medical center; and
  - you meet the patient selection criteria for participation in the qualified clinical trial; and
  - you must have signed, prior to participation in the qualified clinical trial, a statement of consent.
- available clinical or pre-clinical data provide a reasonable expectation that participation is likely to be beneficial to you; and
- it does not duplicate existing studies; and
- it must have a therapeutic intent and must assess the effect of the intervention.

Charges for **covered expenses** you incur for the treatment provided in the clinical trial are payable on the same basis as any disease or illness covered under this plan.

Any care provided in the clinical trial must be for services that are considered **covered expenses** under this plan. They must be consistent with all of the terms and conditions of this plan including but not limited to:

- Aetna’s Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Clinical trial expenses are subject to all of the terms; conditions; provisions; limitations; and exclusions of this plan including, but not limited to: precertification and referral requirements.

Not covered under this plan are:

- any drug or device that is approved by the FDA, even when the off-label use of the drug or device has not been approved by the FDA for that indication, if the drug or device is paid for by the manufacturer, distributor, or provider of the drug or device; and
- any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry; and
- costs of data collection and record-keeping that would not be required but for the clinical trial; and
- any expenses for the management of research; and
- any expenses related to participation in the clinical trial; and
- services and supplies provided "free of charge" by the trial sponsor to the covered person.

**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, drug abuse, mental disorders, or serious mental illnesses.

For Massachusetts residents, to the extent required by law, this also includes the following licensed providers:
- Psychologist;
- Independent Clinical Social Worker;
- Mental Health Counselor;
- Nurse Mental Health Clinical Specialist; and
- Marriage and Family Therapist.

**Telemedicine (GR-9N-11 020 01 ME)**

Covered expenses include the application of telemedicine for covered services provided by a physician acting within the scope of their license as a method of delivery of medical care by which an individual shall receive medical services from a health care provider without in-person contact with the provider. Coverage is provided for only those services that are medically necessary and subject to the terms and conditions of the covered person’s policy. Coverage for health care services under this provision will be consistent with coverage for health care services provided through an in-person consultation.

Telemedicine means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine or e-mail.

**Aetna** may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by **Aetna**.

The deductible, copayment or coinsurance will not exceed any deductible, copayment or coinsurance applicable to an in-person consultation.

**Treatment of Speech, Hearing and Language Disorders (GR-9N 11-145-01 MA)**

The plan will pay for the diagnosis and treatment by individuals licensed as speech-language pathologists or audiologists for acute speech, hearing and language disorders, but only if the services are made for:
- Diagnostic services rendered to find out if, and to what extent, your ability to speak or hear is lost or impaired;
- Rehabilitative services rendered that are expected to restore or improve your ability to speak or hear.

The treatment of speech, hearing and language disorders benefit does not cover:
- Diagnostic or rehabilitative services rendered before you become eligible for coverage or after termination of coverage;
- Special education (including lessons in sign language) to instruct you if your ability to speak or hear is lost or impaired, to function without that ability.
- Hearing aids, hearing aid evaluation tests, and hearing aid batteries;
- Hearing exams required as a condition of employment;
- Diagnostic or rehabilitative services for treatment of speech, hearing, and language disorders:
  - that any school system, by law, must provide; or
  - as to speech therapy, to the extent such coverage is already provided for under Early Intervention Services and Home Health Care Services; or
- Any services unless they are provided in accordance with a specific treatment plan which:
  - details the treatment to be rendered and the frequency and duration of the treatment;
  - provides for ongoing services; and
  - is renewed only if such treatment is still necessary.
**Early Intervention Services Expenses** *(GR9N 11 020 03 MA)*

*Covered expenses* include early intervention services provided by early intervention specialists who are working in early intervention programs certified by the department of public health upon referral by the **Physician** for dependents from birth until thirty six (36) months of age.

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<tr>
<th>PLAN FEATURES</th>
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<th>OUT-OF-NETWORK</th>
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<tr>
<td>Early Intervention <em>(GR-9N-S-10-025-04)</em></td>
<td>No copay, coinsurance or deductible applies.</td>
<td>100% after the calendar year deductible.</td>
</tr>
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</table>

**Autism Spectrum Disorders** *(GR-9N 11-171 02 MA)*

*Covered expenses* include charges the following care prescribed, provided or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed **physician** or a licensed psychologist who determines the care to be **medically necessary**:

- Habilitative or Rehabilitative Care;
- Pharmacy Care;
- Psychiatric Care;
- Psychological Care; and
- Therapeutic Care.

Applied Behavioral Analysis is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder means any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; including:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorders—Not Otherwise Specified

Coverage for the diagnosis and treatment of Autism Spectrum Disorders is payable same as any other illness or injury.

Coverage for the diagnosis and treatment of autism spectrum disorders is not subject to a limit on the number of visits an individual may make to an autism services provider.

Any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of Autism Spectrum Disorders cannot be less than those imposed on coverage for the diagnosis and treatment of physical conditions.

**Common Terms**

**Autism Services Provider:** a person, entity or group that provides treatment of autism spectrum disorders.

**Autism Spectrum Disorders**

Any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

**Board Certified Behavior Analyst**
A behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

**Habilitative or Rehabilitative Care**

Professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual.

**Pharmacy Care**

Medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the contract for other medical conditions.

**Psychiatric Care**

Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

**Psychological Care**

Direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

**Therapeutic Care**

Services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

**Preventive Health Care Services (GR-9N 11-225-01 MA)**

The plan covers preventive health care services even though they are not incurred in connection with an injury or illness. They are included only for a dependent child under 6 years of age. Preventive health care services are services provided for a routine exam of the child. Included are:

- A review and written record of the child's complete medical history;
- Taking measurements and blood pressure;
- Developmental and behavioral assessment;
- Vision and hearing screening, including a newborn hearing screening test performed before the child is discharged from the hospital or birthing center;
- Lead poisoning screening;
- Other diagnostic screening tests including:
  - One series of hereditary and metabolic tests performed at birth; and
  - Urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.
- Immunizations for infectious disease; and
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered expenses will only include charges for preventive health care services performed at birth and at approximately each of the following ages:

<table>
<thead>
<tr>
<th>Age</th>
<th>Description</th>
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<tbody>
<tr>
<td>2 months</td>
<td>18 months</td>
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<tr>
<td>4 months</td>
<td>2 years</td>
</tr>
<tr>
<td>6 months</td>
<td>3 years</td>
</tr>
<tr>
<td>9 months</td>
<td>4 years</td>
</tr>
</tbody>
</table>
Not covered under this benefit are charges incurred for:

- Services which are covered to any extent under any other part of the plan;
- Services which are covered to any extent under any other group plan sponsored by your Employer;
- Services for diagnosis or treatment of a suspected or identified injury or illness;
- Services not performed by a physician or under their direct supervision;
- Medicines, drugs, appliances, equipment or supplies;
- Dental exams.

**Routine Cancer Screenings (GR-9N 11-005-01 MA)**

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

- 1 baseline mammogram, for covered females age 35 but less than 40;
- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap smear every 12 months.

**Treatment of Infertility (GR-9N 11-135 02 MA)**

**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 and Advanced Reproductive Technology (ART) 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.

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, has been recognized and diagnosed as infertility, by a gynecologist, infertility specialist, or your physician, 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.
- The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy; unless that person can document that there has been a successful reversal of a sterilization procedure and has been unable to conceive or produce conception for a period of one (1) year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Booklet-Certificate.
Comprehensive Infertility Services Benefits
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;
- intrauterine insemination.

Advanced Reproductive Technology (ART) Benefits
Advanced Reproductive Technology is defined as:

- in vitro fertilization (IVF-EP);
- zygote intrafallopian transfer (ZIFT);
- gamete intra-fallopian transfer (GIFT);
- cryopreserved embryo transfers;
- intracytoplasmic sperm injection (ICSI); or ovum microsurgery

ART services are defined as: ART services, products, and procedures that are covered expenses under this Booklet-Certificate.

Infertility Case Management is defined as a program administered by Aetna that consists of:

- evaluation of medical records to determine whether ART services are medically necessary;
- determination of whether ART services are covered benefits;
- pre-authorization for ART services by an ART Specialist when ART services are medically necessary and are covered benefits; and
- case management for the provision of ART services for an eligible covered person.

Eligibility for ART Benefits
To be eligible for ART benefits under this Booklet-Certificate, you must meet the requirements above and:

- You must have been unable to achieve a successful pregnancy through less invasive, medically appropriate treatment.
- Be referred by your physician to Aetna's infertility case management unit;
- Be issued pre-authorization for ART services by Aetna's infertility case management unit to an ART specialist.
- ART services are available only from the ART specialists for whom you have been issued a pre-authorization by Aetna's infertility case management unit. Treatment received without pre-authorization will not be covered and you will be responsible for payment of all services.

Covered ART Benefits
The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the Exclusions and Limitations section of the Booklet-Certificate.

- IVF-EP; GIFT; ZIFT; or cryopreserved embryo transfers;
- ICSI or ovum microsurgery;
- payment for charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF-EP program, including fertilization and culture; and
- charges associated with obtaining sperm, egg and/or inseminated egg procurement and processing and bank of sperm or inseminated eggs, for ART, to the extent such costs are not covered by the donor's insurer, if any.
Exclusions and Limitations
Unless otherwise specified above, the following charges will not be payable as covered expenses under this Booklet-Certificate:

- ART services for a female attempting to become pregnant who, prior to enrolling in the infertility program, has not had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older);
- ART services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal; unless that person can document that there has been a successful reversal of a sterilization procedure and has been unable to conceive or produce conception for a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35;
- Reversal of sterilization surgery;
- 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. This exclusion does not apply to sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any;
- 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 or related to the treatment of infertility that are not medically necessary;
- If you have Prescription Drug Coverage that includes oral and self-injectable infertility drugs, then oral and self-injectable infertility drugs are excluded under your medical plan. If you do not have Prescription Drug Coverage for oral and self-injectable infertility drugs then they are covered same as any other prescription under your medical plan;
- Any services or supplies provided without pre-authorization from Aetna’s infertility case management unit;
- Infertility and ART Services that do not meet the Medical Necessity guidelines, for example, women who are deemed to be in natural menopause versus women in premature ovarian failure which would be subject to medical review;
- Ovulation induction and intrauterine insemination services if you are not infertile;
- Services and supplies obtained without pre-authorization from Aetna’s infertility case management unit.

Coverage under this benefit will terminate immediately upon termination of coverage under this Booklet-Certificate, subject to group continuation coverage requirements under COBRA or state continuation laws.

Important Note
Treatment received without pre-authorization will not be covered. You will be responsible for full payment of the services.

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<tr>
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<tbody>
<tr>
<td><strong>Infertility Treatment</strong> (GR-9N 510-55-01 MA)</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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<tr>
<td><strong>Basic and Comprehensive Infertility Expenses</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
</tr>
<tr>
<td><strong>Advanced Reproductive Technology (ART) Expenses</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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Diabetic Equipment, Supplies and Education (GR-9N 11-135 02 MA)
**Covered expenses** include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- Insulin and Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets, including blood glucose monitoring strips, ketone strips;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training;
- Foot care to minimize the risk of infection;
- All lab tests and urinary profiles;
- Voice synthesizers and visual magnifying aids;
- Therapeutic/molded shoes and shoe inserts;
- Insulin pump supplies;
- Insulin pens; and
- Oral medications.

**Physician Visits** (GR-9N 11-020-01 MA)

**Covered expenses** also include:

- Diabetic Self-Management Education: Training designed to instruct a person in self-management of diabetes. It may also include training in self care or diet. Such charges must be made by:
  - a physician, nurse practitioner, clinical nurse specialist; or
  - a pharmacy or dietician who is legally qualified by the Commonwealth of Massachusetts to provide diabetic management education.
- Your diabetic equipment and self-management education services benefit does **not** cover:
  - a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
  - a general program not just for diabetics; or
  - a program made up of services not generally accepted as necessary for the management of diabetes.

**Important Reminder**

Certain procedures need to be **precertified** by Aetna. Refer to *How the Plan Works* for more information about precertification.

**Diabetic Equipment, Supplies and Education**

Payable in accordance with the type of expense incurred and the place where service is provided.

**Prescription Drug** (GR-9N 34-080-01 MA)

15
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:

- Drugs and medicines prescribed for the treatment of cancer or HIV/AIDS even if the off-label use of the drug has not been approved by the FDA for that indication. However, such drug for the treatment of such indication is in one of the standard reference compendia or in medical literature. The term "standard reference compendia" means the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information. The term "medical literature" means published scientific studies appearing in any peer-reviewed national professional journal.

**Hormone Replacement Therapy** *(GR-9N 11-200-01 MA)*

The plan will pay for outpatient services and supplies related to your hormone replacement therapy for peri and post menopausal women on the same basis as any other illness.

**Contraception Services** *(GR-9N 11-005-01 MA)*

_Covered expenses_ include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a _physician_ provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

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

_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.

If the mother is discharged earlier, the plan will pay for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit be conducted by a registered nurse, _physician_, or certified nurse midwife; and provided that any subsequent home visits determined to be clinically necessary shall be provided by a licensed health care provider.

_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.

# Treatment of Mental Disorders and Substance Abuse

## Treatment of Mental Disorders

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers.

**Important Note**

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

If you require ongoing care from a behavioral health provider, you may receive a standing referral to such behavioral health provider. The behavioral health provider agrees to a treatment plan and provides the primary care physician with all necessary clinical and administrative information on a regular basis. The health care services provided must be consistent with the terms of the Booklet-Certificate.

In addition to the conditions listed in the definition of mental disorders, the plan will pay for the following:

**Rape Related Mental or Emotional Disorders**

Coverage shall be provided for the diagnosis and treatment of rape related mental or emotional disorders if you are a victim of a rape or a victim of an assault with intent to commit rape under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.

**Children and Adolescents under the age of 19**

Benefits shall be covered under the same terms and conditions and which are not less extensive than coverage provided for any other health care for physical illness, for children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care physician, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including but not limited to:

1. an inability to attend school as a result of such a disorder;
2. the need to hospitalize the child or adolescent as a result of such a disorder;
3. a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others, **Aetna** shall continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.

Please note that if COBRA or state continuation is selected, then all plan benefits will be available. If COBRA or state continuation is not selected, any premiums paid by the Policyholder to continue the mental health benefits beyond age 19 will continue health benefits only and COBRA or state continuation eligibility will not be extended.

**Psychopharmacological Services/Neuropsychological Assessment Services**

Coverage shall be provided for the diagnosis and treatment of psychopharmacological services/neuropsychological assessment services under the same term and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.
Benefits are payable for charges incurred in a hospital, as well as a facility under the direction and supervision of the department of mental health, in a private mental hospital, or behavioral health provider's office for the treatment of mental disorders as follows:

Inpatient Treatment
Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, as well as a facility under the direction and supervision of the department of mental health, in a private mental hospital, or in a substance abuse facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Intermediate Care Treatment
Covered Medical Expenses include, but are not limited to, Level III community-based detoxification, acute and other residential treatment, clinically managed detoxification services, partial hospitalization confinement treatment, Intensive Outpatient Programs (IOP), in-home therapy services, day treatment and crisis stabilization.

Important Reminder
Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.

Outpatient Treatment
Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, as well as a facility under the direction and supervision of the department of mental health, or in a private mental hospital. Outpatient treatment may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.

IMPORTANT REMINDERS
- Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.
- Please refer to the Schedule of Benefits for any copayments/deductibles, maximums, coinsurance limits or maximum out-of-pocket limits that may apply to your mental disorders and substance abuse benefits.

Treatment of Substance Abuse
Covered expenses include charges made for the treatment of substance abuse by behavioral health providers.

IMPORTANT NOTE
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See Health Plan Exclusions and Limits for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

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

Please refer to the Schedule of Benefits for any substance abuse deductibles, maximums, coinsurance limits or maximum out-of-pocket limits that may apply to your substance abuse benefits.
Inpatient Treatment
This Plan covers room and board at the semi-private room rate and other services and supplies provided during your stay in a hospital as well as a facility under the direction and supervision of the department of mental health, in a private mental hospital, or in a substance abuse facility appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

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

Important Reminder
Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.

Intermediate Care Treatment
Covered Medical Expenses include, but are not limited to, Level III community-based detoxification, acute residential treatment, partial confinement treatment, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health.

Outpatient Treatment
Outpatient treatment includes charges for treatment received for substance abuse while not confined as a full-time inpatient in a hospital, as well as a facility under the direction and supervision of the department of mental health, or in a private mental hospital, or in a substance abuse facility. Outpatient treatment may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.

Important Reminders:

- Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.
- Please refer to the Schedule of Benefits for any copayments/deductibles, maximums, coinsurance limits or maximum out-of-pocket limits that may apply to your substance abuse benefits.

Behavioral Health Provider (GR-9N 34-010-01 MA)
A licensed facility, organization or other health care provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, mental disorders acting within the scope of the applicable license. This includes:

- Hospitals;
- Psychiatric hospitals;
- Residential treatment facilities;
- Psychiatric physicians;
- Psychologists;
- Social workers;
- Psychiatric nurses;
- Addictionologists;
- Substance abuse facility licensed by the department of mental health;
- Level III community-based detoxification; acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health;
- Mental health or substance abuse clinic licensed by the department of public health;
- A public community mental health center;
- Professional office or home-based services;
- Licensed independent clinical social worker;
- Licensed mental health counselor;
- Licensed nurse mental health clinical specialist; or
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

**Mental Disorder** *(GR-9N 34-065 04 MA)*

An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist, a psychiatric social worker, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

Any one of the following conditions is a mental disorder under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizoaffective disorder.
- Schizophrenia.
- Paranoia and other psychotic disorders.
- Delirium and dementia.
- Affective disorders.
- Eating disorders.
- Post traumatic stress disorders.
- Substance Abuse.
- All other mental disorders not otherwise identified and which are described in the most recent edition of the diagnostic and statistical Manual of Mental Disorders (DSM).

Also included is any other mental condition which requires Medically Necessary treatment.

### PLAN FEATURES

#### NETWORK

**Mental Disorders and Substance Abuse** *(GR-9N S-10 062 01 MA)*

<table>
<thead>
<tr>
<th>Hospital Facility Expenses</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board</td>
<td>80% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td>Other than Room and Board</td>
<td>80% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td>Physician Services</td>
<td>80% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
</tr>
</tbody>
</table>

**Inpatient Residential Treatment Facility Expenses**

<p>| 80% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |</p>
<table>
<thead>
<tr>
<th>Services</th>
<th>Cost Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td>$25 per visit copay then the plan pays 100% then the plan pays 100% after the Calendar Year deductible applies.</td>
</tr>
</tbody>
</table>

**Thirty-One Day Continuation** *(GR-9N 31-015-01 MA)*

Coverage under this plan which terminates in accordance with the prior terms of this section will be continued for 31 more days, subject to the following.

- Termination is not due to discontinuance of the Group Contract, or failure to make any required contributions.
- This plan's benefits will be reduced by any other benefits of like kind for which the person becomes eligible.
- If this plan provides a medical expense benefits conversion privilege the following must be submitted to Aetna within the 31 day period of continuation:
  - Application for the personal policy; and
  - The premium.

This applies unless the person elects any other available continuation.

**Continuation of Coverage for Your Former Spouse**

If your health expense benefit coverage for your dependent spouse would terminate because of divorce or of separate support, you may continue any such coverage in force by continuing premium payments.

Coverage may be continued if the valid decree of dissolution of marriage states that you do not have to provide medical or dental coverage for your former spouse.

Coverage will be continued beyond the first to occur of:

- The date you are no longer covered under this Plan.
- The date dependent coverage is discontinued under this Plan for your Eligible Class.
- The end of the period for which required contributions have been made.
- The end of any period set forth in the valid decree of dissolution of marriage during which you are required to provide medical or dental coverage for your former spouse.
- The date you or your former spouse remarries. In the event of remarriage of the group plan member, the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family plan or issuance of an individual plan.

Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to the divorced or separated spouse at their last known address together with notice of the right to reinstate coverage retroactively to the date of cancellation.

**Continuation of Coverage: Employment Ceases**

If your employment terminates due to involuntary lay-off, you may continue Health Expense Coverage (except Dental Expense Coverage) for you and your dependents for 39 weeks. You must request that your coverage continue within 31 days after it would cease due to involuntary lay-off.

Coverage will cease before the end of the 39 weeks on the first to occur of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.
- The date Health Expense Coverage discontinues for employees of your former employer.
- The end of a period equal to the length of time you were last insured.
Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

**Continuation of Coverage: Plant Closing**

If your employment terminated due to a plant closing or partial closing, you may continue Health Expense Coverage, except Dental Expense Coverage for you and your dependents for 90 days. You must request that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Coverage will cease before the end of the 90 days on the first of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

The following terms are defined by Massachusetts law:

- Plant closing.
- Partial closing.

**Continuation of Coverage for Your Dependents After Your Death**

If you die while covered under any part of this plan, any Health Expense Coverage then in force for your dependents will be continued if:

- Your coverage is not then being continued after your employment has stopped due to involuntary lay-off.
- Such coverage is requested within 31 days after your death.
- Premium payments are made for the coverage.

Your spouse's coverage will cease when your spouse remarries. Any dependent’s coverage, including your spouse's, will end when any one of the following happens:

- The end of the 39 week period right after the date the dependent's coverage would otherwise cease.
- The end of a period equal to the length of time you were last covered.
- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for coverage under this plan or another group plan.
- Dependent coverage ceases under this plan.
- Any required contributions cease.

**Continuation of Coverage for Your Child**

The terms of this Continuation of Coverage apply only to your dependent child:

- who attains the limiting age for eligibility; and
- whose coverage under this Plan would otherwise terminate; and
- who is engaged in an ongoing treatment under this Plan, in accordance with a written treatment plan, for a mental, behavioral, or emotional disorder.
Such child's health expenses coverage, except dental expense coverage, may be continued, if:

- written request for such continuation is made within 31 days of the date coverage terminates; and
- that such request includes the following:
  - an agreement to pay up to 100% of the cost to the plan; and
  - evidence, satisfactory to Aetna, of the existence of such a mental, behavioral, or emotional disorder.

Premium payments must be made.

Coverage will cease on the first to occur of:

- the end of a 36 month period that starts on the date coverage would otherwise terminate (but not before the date a course of treatment for a non-biological mental disorder for children or adolescents under the age of 19, as specified in the treatment plan, is completed); or
- the date the child fails to provide the required proof that the course of treatment is still ongoing; or
- the date the child is eligible for similar benefits under any group plan; or
- the date the child becomes eligible for other coverage under the Group Policy; or
- the date the child fails to make any required contributions; or
- the date health expense coverage under this Plan discontinues for employees of your employer.

Aetna will have the right to require proof of the continuation of the course of treatment. Aetna also has the right to examine your child as often as needed while the course of treatment continues at its own expense. An exam will not be required more often than once each year.

If any coverage being continued ceases, the child may apply for a personal policy in accordance with the Conversion Privilege.

Mark T. Bertolini  
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company  
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: President And Trustees Of Bates College
Group Policy No.: GP-869807
Rider: Massachusetts ET Medical - OC PPO w/ HSA
Issue Date: June 16, 2015
Effective Date: January 1, 2015

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Massachusetts. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits.** You are only entitled to these benefits, if you are a resident of Massachusetts, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

**Physician Profiling**

Physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

**Interpreter and Translation Services**

You may contact Member Services at the toll-free telephone number listed on your I.D. card to receive information on interpreter and translation services related to administrative procedures. A TDD# for the hearing impaired is also available.

**French**

**Services d'interprétation et de traduction**

Vous pouvez contacter les services aux membres au numéro de téléphone sans frais indiqué sur votre carte d'identification pour recevoir de l'information sur les services d'interprétation et de traduction se rapportant aux procédures administratives. Les professionnels du service à la clientèle Aetna ont accès à des services de traduction par le biais des services linguistiques téléphoniques de AT&T. Un numéro de téléphone ATME est aussi disponible pour les malentendants.
Greek

Υπηρεσίες Μεταφράσεως
Гια να λάβετε πληροφορίες σχετικά με την διαδικασία διοικητική, μπορείτε να ερχόσαστε σε επαφή με την Υπηρεσία για τα Μελή στον αριθμό (χρονίς διοίκια) που βρίσκεται επάνω στην εξακρίβωση σας ταυτότητας. Οι επαγγελματικοί υπαλλήλοι (του τμήματος της Αετνα το οποίο ανασχολείται με τους πελάτες) μπορούν να χρησιμοποιήσουν την μεταφραστική υπηρεσία της εταιρείας AT&T.

Italian

Servizi di traduzione e di interpretariato
Per ottenere informazioni sui servizi di traduzione e interpretariato connessi a procedure amministrative, potete rivolgervi al Servizio Membri chiamando il numero di linea verde indicato sulla vostra carta di ID. I professionisti del servizio clientela della Aetna hanno accesso ai servizio di traduzione della linea linguistica della AT&T. È anche disponibile un No TDD per i deboli di udito.

Portuguese

Serviços de Intérprete e de Tradução
Você poderá entrar em contato com os Serviços dos Associados ao telefone livre de tarifa indicado no seu cartão de identificação para obter informações sobre serviços de intérprete e de tradução com relação aos procedimentos administrativos. Os profissionais dos serviços aos clientes têm acesso aos serviços de tradução através da linha de idiomas da AT&T. Existe também uma linha TDD para quem tem dificuldades com a audição.

Russian

Услуги по устному и письменному переводу
Чтобы получить информацию о предоставляемых услугах устного и письменного перевода, вы можете обратиться в отдел обслуживания членов программы по бесплатному номеру телефона, указанному на вашей членской карточке. Сотрудники Aetna по обслуживанию клиентов имеют доступ к переводческим услугам по языковой линии AT&T. Имеется также устройство связи для лиц с дефектами слуха (TDD).

Spanish

Servicio de Intérprete y Traducción
Usted puede ponerse en contacto con Servicios a Miembros, al número de teléfono gratis que aparece en su tarjeta de identificación para recibir información sobre servicios de intérprete y traducción relativo a los procedimientos administrativos. Los profesionales de servicio a clientes de Aetna tienen acceso a los servicios de traducción por medio de la línea de idiomas de AT&T. Además hay un número de TDD para las personas con impedimento de audición.

Haitian-Creole

Sèvis intèprèt ak tradiktè
Ou kapab pran kontak avèk Sèvis pou manm-yo si ou rele nimewo telegòn gratis ki sou kat I.D.-ou-a (idantifikasyon) pou ou jwenn ranséyman sou sèvis intèprèt ak tradiktè konsénan pwosedi administratif. Pwofesyonnel nan sèvis kliyan “Aetna” gen mwayden jwenn sèvis tradiksyon nan “AT&T language line” (sèvis lang AT&T). Yon nimewo TDD disponnib tou pou moun ki pa tande byen.
In no event will the covered amount for In-Network charges exceed more than 20% of the covered amount for Out-of-Network charges.
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, or whose parent is your child and is covered as a dependent under the plan.

**When You Receive a Qualified Child Support Order** *(GR-9N 29-015-01 MA)*

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, 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.

If you fail to make an application to obtain coverage of a child, Aetna shall enroll such child upon application by such child’s other parent, by the division of medical assistance or upon receipt of a national medical support notice from the IVD agency.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing 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 or QDRSO, 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.

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

**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;
- A durable brace that is custom made for and fitted for you;
- A scalp hair prosthesis (wig) for hair loss due to treatment of any form of cancer or leukemia;
- Therapeutic/molded shoes and shoe inserts required for the treatment of or to prevent complications of diabetes.

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

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items or any item listed in the Exclusions section.

### PPO Medical Plan (GR-9N S10-80-01 MA)

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
</tbody>
</table>

Any coinsurance requirement for artificial limb devices to replace, in whole or in part, an arm or leg will not exceed 20%, unless such coinsurance applies to all covered benefits. With respect to Out of Network charges, any coinsurance will not exceed 40% of the cost unless such coinsurance applies to all covered benefits under the plan.

### Scalp Hair Prosthesis for Cancer or Leukemia Patients

(GR-9N S10-95-01 MA)

| Maximum Benefit per Calendar Year | $350 | $350 |

### Cleft Lip or Palate Treatment

**Treatment of Cleft Lip or Palate of Dependent Children Under Age 18**

**Covered expenses** include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Medical, dental, oral surgery and facial surgery, surgical management including pre- and post-operative care provided by oral and plastic surgeons;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Preventative and restorative dentistry to ensure good health;
Adequate dental structures for orthodontic treatment or prosthetic management therapy;
Installation of crowns;
Diagnostic services provided by a physician to determine the extent of loss or impairment in your speaking or hearing ability;
Speech therapy to treat delays in speech development given by a physician. Such therapy is expected to overcome congenital or early acquired handicaps;
Speech therapy. Coverage includes speech aids and training to use the speech aids;
Psychological assessment and counseling;
Genetic assessment and counseling;
Hearing aids;
Audiology;
Nutrition services;
Audiological assessment, treatment and management, including surgically implanted amplification devices; and

A legally qualified audiologist or speech therapist will be deemed a physician for purposes of this coverage.

If such services are prescribed by the treating physician or surgeon and such physician or surgeon certifies that such services are medically necessary and consequent to the treatment of the cleft lip, cleft palate or both.

Payment for dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate will not be covered under this section.

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

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

Hearing Aids Expense

Covered expenses include charges incurred by a covered person for the cost of one hearing aid per hearing impaired ear every 36 months upon written statement from the covered person’s treating physician that the hearing aid(s) are necessary regardless of etiology.

Covered expenses also include related services prescribed by a licensed audiologist or hearing instrument specialist, including the initial hearing aid evaluation, fitting and adjustments and supplies, including ear molds.

Coverage is provided under the same terms and conditions as for any other condition.

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<thead>
<tr>
<th>Hearing Aids</th>
<th>100% per item after Calendar Year deductible</th>
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<td>(GR-9N-3-31-80-03 MA)</td>
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Clinical Trial Expenses  (GR-9N 11-210-01 MA)
This Plan will pay for medically necessary and routine patient care, physician, and facility charges you incur when enrolled in a qualified clinical trial study.
A "qualified clinical trial" means a patient research study that meets the following criteria:

- it must be intended to treat cancer; and
- it must be peer reviewed and approved by one of the following:
  - one of the United States Institutes of Health;
  - a center or cooperative group of the National Institutes of Health;
  - a qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
  - the Food and Drug Administration (FDA) pursuant to an investigational new drug exemption;
  - the Department of Defense;
  - the Department of Veterans Affairs; or
- with respect to a Phase II, III and IV clinical trial
  - a qualified institutional review board; and
  - it must be provided by a provider of health care which has the experience and training to provide the treatment in a capable manner; and
- with respect to Phase I clinical trials
  - it must be provided by an academic medical center or affiliated facility, and the providers conducting the trial shall have staff privileges at the academic medical center; and
  - you meet the patient selection criteria for participation in the qualified clinical trial; and
  - you must have signed, prior to participation in the qualified clinical trial, a statement of consent.
- available clinical or pre-clinical data provide a reasonable expectation that participation is likely to be beneficial to you; and
- it does not duplicate existing studies; and
- it must have a therapeutic intent and must assess the effect of the intervention.

Charges for covered expenses you incur for the treatment provided in the clinical trial are payable on the same basis as any disease or illness covered under this plan.

Any care provided in the clinical trial must be for services that are considered covered expenses under this plan. They must be consistent with all of the terms and conditions of this plan including but not limited to:

- Aetna's Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Clinical trial expenses are subject to all of the terms; conditions; provisions; limitations; and exclusions of this plan including, but not limited to: precertification and referral requirements.

Not covered under this plan are:

- any drug or device that is approved by the FDA, even when the off-label use of the drug or device has not been approved by the FDA for that indication, if the drug or device is paid for by the manufacturer, distributor, or provider of the drug or device; and
- any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry; and
- costs of data collection and record-keeping that would not be required but for the clinical trial; and
- any expenses for the management of research; and
- any expenses related to participation in the clinical trial; and
- services and supplies provided "free of charge" by the trial sponsor to the covered person.

**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, drug abuse, mental disorders, or serious mental illnesses.

For Massachusetts residents, to the extent required by law, this also includes the following licensed providers:

- Psychologist;
- Independent Clinical Social Worker;
- Mental Health Counselor;
- Nurse Mental Health Clinical Specialist; and
- Marriage and Family Therapist.

**Telemedicine (GR-9N-11 020 01 ME)**

**Covered expenses** include the application of telemedicine for covered services provided by a physician acting within the scope of their license as a method of delivery of medical care by which an individual shall receive medical services from a health care provider without in-person contact with the provider. Coverage is provided for only those services that are medically necessary and subject to the terms and conditions of the covered person’s policy. Coverage for health care services under this provision will be consistent with coverage for health care services provided through an in-person consultation.

Telemedicine means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine or e-mail.

Aetna may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by Aetna.

The deductible, copayment or coinsurance will not exceed any deductible, copayment or coinsurance applicable to an in-person consultation.

**Treatment of Speech, Hearing and Language Disorders (GR-9N 11-145-01 MA)**

The plan will pay for the diagnosis and treatment by individuals licensed as speech-language pathologists or audiologists for acute speech, hearing and language disorders, but only if the services are made for:

- Diagnostic services rendered to find out if, and to what extent, your ability to speak or hear is lost or impaired;
- Rehabilitative services rendered that are expected to restore or improve your ability to speak or hear.

The treatment of speech, hearing and language disorders benefit does not cover:

- Diagnostic or rehabilitative services rendered before you become eligible for coverage or after termination of coverage;
- Special education (including lessons in sign language) to instruct you if your ability to speak or hear is lost or impaired, to function without that ability.
- Hearing aids, hearing aid evaluation tests, and hearing aid batteries;
- Hearing exams required as a condition of employment;
- Diagnostic or rehabilitative services for treatment of speech, hearing, and language disorders:
  - that any school system, by law, must provide; or
  - as to speech therapy, to the extent such coverage is already provided for under Early Intervention Services and Home Health Care Services; or
- Any services unless they are provided in accordance with a specific treatment plan which:
  - details the treatment to be rendered and the frequency and duration of the treatment;
  - provides for ongoing services; and
  - is renewed only if such treatment is still necessary.
Early Intervention Services Expenses *(GRN 11 020 03 MA)*

**Covered expenses** include early intervention services provided by early intervention specialists who are working in early intervention programs certified by the department of public health upon referral by the *Physician* for dependents from birth until thirty six (36) months of age.

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<th>PLAN FEATURES</th>
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<tr>
<td>Early Intervention <em>(GR-9N-S-10-023-04)</em></td>
<td>100% after the calendar year deductible.</td>
<td>100% after the calendar year deductible.</td>
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**Autism Spectrum Disorders** *(GRN 11-171 02 MA)*

**Covered expenses** include charges the following care prescribed, provided or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed *physician* or a licensed psychologist who determines the care to be *medically necessary*:

- Habilitative or Rehabilitative Care;
- Pharmacy Care;
- Psychiatric Care;
- Psychological Care; and
- Therapeutic Care.

Applied Behavioral Analysis is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder means any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; including:

- Autistic Disorder;
- Rett’s Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorders--Not Otherwise Specified

Coverage for the diagnosis and treatment of Autism Spectrum Disorders is payable same as any other *illness* or *injury*.

Coverage for the diagnosis and treatment of autism spectrum disorders is not subject to a limit on the number of visits an individual may make to an autism services provider.

Any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of Autism Spectrum Disorders cannot be less than those imposed on coverage for the diagnosis and treatment of physical conditions.

**Common Terms**

**Autism Services Provider**: a person, entity or group that provides treatment of autism spectrum disorders.

**Autism Spectrum Disorders**

Any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger’s disorder and pervasive developmental disorders not otherwise specified.

**Board Certified Behavior Analyst**
A behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

**Habilitative or Rehabilitative Care**

Professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual.

**Pharmacy Care**

Medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the contract for other medical conditions.

**Psychiatric Care**

Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

**Psychological Care**

Direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

**Therapeutic Care**

Services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

**Preventive Health Care Services** *(GR-9N 11-225-01 MA)*

The plan covers preventive health care services even though they are not incurred in connection with an injury or illness. They are included only for a dependent child under 6 years of age.

Preventive health care services are services provided for a routine exam of the child. Included are:

- A review and written record of the child's complete medical history;
- Taking measurements and blood pressure;
- Developmental and behavioral assessment;
- Vision and hearing screening, including a newborn hearing screening test performed before the child is discharged from the hospital or birthing center;
- Lead poisoning screening;
- Other diagnostic screening tests including:
  - One series of hereditary and metabolic tests performed at birth; and
  - Urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.
- Immunizations for infectious disease; and
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered expenses will only include charges for preventive health care services performed at birth and at approximately each of the following ages:

- 2 months
- 4 months
- 6 months
- 9 months
- 18 months
- 2 years
- 3 years
- 4 years
Not covered under this benefit are charges incurred for:

- Services which are covered to any extent under any other part of the plan;
- Services which are covered to any extent under any other group plan sponsored by your Employer;
- Services for diagnosis or treatment of a suspected or identified injury or illness;
- Services not performed by a physician or under their direct supervision;
- Medicines, drugs, appliances, equipment or supplies;
- Dental exams.

Routine Cancer Screenings *(GR-9N 11-005-01 MA)*
Covered expenses include charges incurred for routine cancer screening as follows:

- 1 baseline mammogram, for covered females age 35 but less than 40;
- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap smear every 12 months.

Treatment of Infertility *(GR-9N 11-135 02 MA)*

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 and Advanced Reproductive Technology (ART) 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.

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, has been recognized and diagnosed as infertility, by a gynecologist, infertility specialist, or your physician, 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.
- The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy; unless that person can document that there has been a successful reversal of a sterilization procedure and has been unable to conceive or produce conception for a period of one (1) year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Booklet-Certificate.
Comprehensive Infertility Services Benefits
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; and
- intruterine insemination.

Advanced Reproductive Technology (ART) Benefits
Advanced Reproductive Technology is defined as:

- in vitro fertilization (IVF-EP);
- zygote intrafallopian transfer (ZIFT);
- gamete intra-fallopian transfer (GIFT);
- cryopreserved embryo transfers;
- intracytoplasmic sperm injection (ICSI); or ovum microsurgery

ART services are defined as: ART services, products, and procedures that are covered expenses under this Booklet-Certificate.

Infertility Case Management is defined as a program administered by Aetna that consists of:

- evaluation of medical records to determine whether ART services are medically necessary;
- determination of whether ART services are covered benefits;
- pre-authorization for ART services by an ART Specialist when ART services are medically necessary and are covered benefits; and
- case management for the provision of ART services for an eligible covered person.

Eligibility for ART Benefits
To be eligible for ART benefits under this Booklet-Certificate, you must meet the requirements above and:

- You must have been unable to achieve a successful pregnancy through less invasive, medically appropriate treatment.
- Be referred by your physician to Aetna’s infertility case management unit;
- Be issued pre-authorization for ART services by Aetna’s infertility case management unit to an ART specialist.
- ART services are available only from the ART specialists for whom you have been issued a pre-authorization by Aetna’s infertility case management unit. Treatment received without pre-authorization will not be covered and you will be responsible for payment of all services.

Covered ART Benefits
The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the Exclusions and Limitations section of the Booklet-Certificate.

- IVF-EP; GIFT; ZIFT; or cryopreserved embryo transfers;
- ICSI or ovum microsurgery;
- payment for charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF-EP program, including fertilization and culture; and
- charges associated with obtaining sperm, egg and/or inseminated egg procurement and processing and bank of sperm or inseminated eggs, for ART, to the extent such costs are not covered by the donor’s insurer, if any.
Exclusions and Limitations

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

- ART services for a female attempting to become pregnant who, prior to enrolling in the infertility program, has not had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older);
- ART services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal; unless that person can document that there has been a successful reversal of a sterilization procedure and has been unable to conceive or produce conception for a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35;
- Reversal of sterilization surgery;
- 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. This exclusion does not apply to sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor’s insurer, if any;
- 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 or related to the treatment of infertility that are not medically necessary;
- If you have Prescription Drug Coverage that includes oral and self-injectable infertility drugs, then oral and self-injectable infertility drugs are excluded under your medical plan. If you do not have Prescription Drug Coverage for oral and self-injectable infertility drugs then they are covered same as any other prescription under your medical plan;
- Any services or supplies provided without pre-authorization from Aetna’s infertility case management unit;
- Infertility and ART Services that do not meet the Medical Necessity guidelines, for example, women who are deemed to be in natural menopause versus women in premature ovarian failure which would be subject to medical review;
- Ovulation induction and intrauterine insemination services if you are not infertile;
- Services and supplies obtained without pre-authorization from Aetna’s infertility case management unit.

Coverage under this benefit will terminate immediately upon termination of coverage under this Booklet-Certificate, subject to group continuation coverage requirements under COBRA or state continuation laws.

Important Note

Treatment received without pre-authorization will not be covered. You will be responsible for full payment of the services.

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<tr>
<td>Basic and Comprehensive Infertility Expenses</td>
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<td>Advanced Reproductive Technology (ART) Expenses</td>
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Diabetic Equipment, Supplies and Education (GR-9N 11-135 02 MA)
**Covered expenses** include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- Insulin and Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets, including blood glucose monitoring strips, ketone strips;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training;
- Foot care to minimize the risk of infection;
- All lab tests and urinary profiles;
- Voice synthesizers and visual magnifying aids;
- Therapeutic/molded shoes and shoe inserts;
- Insulin pump supplies;
- Insulin pens; and
- Oral medications.

**Physician Visits** *(GR-9N 11-020-01 MA)*

**Covered expenses** also include:

- Diabetic Self-Management Education: Training designed to instruct a person in self-management of diabetes. It may also include training in self care or diet. Such charges must be made by:
  - a **physician**, nurse practitioner, clinical nurse specialist; or
  - a **pharmacy** or dietician who is legally qualified by the Commonwealth of Massachusetts to provide diabetic management education.
- Your diabetic equipment and self-management education services benefit does **not** cover:
  - a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
  - a general program not just for diabetics; or
  - a program made up of services not generally accepted as necessary for the management of diabetes.

**Important Reminder**

Certain procedures need to be **precertified** by Aetna. Refer to *How the Plan Works* for more information about **precertification**.

**Diabetic Equipment, Supplies and Education**  Payable in accordance with the type of expense incurred and the place where service is provided.

**Prescription Drug** *(GR-9N 34-080-01 MA)*
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:

- Drugs and medicines prescribed for the treatment of cancer or HIV/AIDS even if the off-label use of the drug has not been approved by the FDA for that indication. However, such drug for the treatment of such indication is in one of the standard reference compendia or in medical literature. The term "standard reference compendia" means the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information. The term "medical literature" means published scientific studies appearing in any peer-reviewed national professional journal.

**Hormone Replacement Therapy (GR-9N 11-200-01 MA)**

The plan will pay for outpatient services and supplies related to your hormone replacement therapy for peri and post menopausal women on the same basis as any other illness.

**Contraception Services (GR-9N 11-005-01 MA)**

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a physician provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

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

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.

If the mother is discharged earlier, the plan will pay for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit be conducted by a registered nurse, physician, or certified nurse midwife; and provided that any subsequent home visits determined to be clinically necessary shall be provided by a licensed health care provider.

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.

**Treatment of Mental Disorders and Substance Abuse**

**Treatment of Mental Disorders**

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers.

**Important Note**

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

If you require ongoing care from a behavioral health provider, you may receive a standing referral to such behavioral health provider. The behavioral health provider agrees to a treatment plan and provides the primary care physician with all necessary clinical and administrative information on a regular basis. The health care services provided must be consistent with the terms of the Booklet-Certificate.

In addition to the conditions listed in the definition of mental disorders, the plan will pay for the following:

**Rape Related Mental or Emotional Disorders**

Coverage shall be provided for the diagnosis and treatment of rape related mental or emotional disorders if you are a victim of a rape or a victim of an assault with intent to commit rape under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.

**Children and Adolescents under the age of 19**

Benefits shall be covered under the same terms and conditions and which are not less extensive than coverage provided for any other health care for physical illness, for children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care physician, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including but not limited to:

1. an inability to attend school as a result of such a disorder;
2. the need to hospitalize the child or adolescent as a result of such a disorder;
3. a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others, Aetna shall continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.

Please note that if COBRA or state continuation is selected, then all plan benefits will be available. If COBRA or state continuation is not selected, any premiums paid by the Policyholder to continue the mental health benefits beyond age 19 will continue health benefits only and COBRA or state continuation eligibility will not be extended.

**Psychopharmacological Services/Neuropsychological Assessment Services**

Coverage shall be provided for the diagnosis and treatment of psychopharmacological services/neuropsychological assessment services under the same term and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.
Benefits are payable for charges incurred in a hospital, as well as a facility under the direction and supervision of the department of mental health, in a private mental hospital, or behavioral health provider’s office for the treatment of mental disorders as follows:

Inpatient Treatment
Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, as well as a facility under the direction and supervision of the department of mental health, in a private mental hospital, or in a substance abuse facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Intermediate Care Treatment
Covered Medical Expenses include, but are not limited to, Level III community-based detoxification, acute and other residential treatment, clinically managed detoxification services, partial hospitalization confinement treatment, Intensive Outpatient Programs (IOP), in-home therapy services, day treatment and crisis stabilization.

Important Reminder
Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.

Outpatient Treatment
Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, as well as a facility under the direction and supervision of the department of mental health, or in a private mental hospital. Outpatient treatment may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.

Important Reminders
- Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.
- Please refer to the Schedule of Benefits for any copayments/deductibles, maximums, coinsurance limits or maximum out-of-pocket limits that may apply to your mental disorders and substance abuse benefits.

Treatment of Substance Abuse
Covered expenses include charges made for the treatment of substance abuse by behavioral health providers.

Important Note
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See Health Plan Exclusions and Limits for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

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

Please refer to the Schedule of Benefits for any substance abuse deductibles, maximums, coinsurance limits or maximum out-of-pocket limits that may apply to your substance abuse benefits.
Inpatient Treatment
This Plan covers room and board at the semi-private room rate and other services and supplies provided during your stay in a hospital as well as a facility under the direction and supervision of the department of mental health, in a private mental hospital, or in a substance abuse facility appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

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

Important Reminder
Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.

Intermediate Care Treatment
Covered Medical Expenses include, but are not limited to, Level III community-based detoxification, acute residential treatment, partial confinement treatment, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health.

Outpatient Treatment
Outpatient treatment includes charges for treatment received for substance abuse while not confined as a full-time inpatient in a hospital, as well as a facility under the direction and supervision of the department of mental health, or in a private mental hospital, or in a substance abuse facility. Outpatient treatment may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.

Important Reminders:

- Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.
- Please refer to the Schedule of Benefits for any copayments/deductibles, maximums, coinsurance limits or maximum out-of-pocket limits that may apply to your substance abuse benefits.

Behavioral Health Provider (GR-9N 34-010-01 MA)
A licensed facility, organization or other health care provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, mental disorders acting within the scope of the applicable license. This includes:

- Hospitals;
- Psychiatric hospitals;
- Residential treatment facilities;
- Psychiatric physicians;
- Psychologists;
- Social workers;
- Psychiatric nurses;
- Addictionologists;
- Substance abuse facility licensed by the department of mental health;
- Level III community-based detoxification; acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health;
- Mental health or substance abuse clinic licensed by the department of public health;
- A public community mental health center;
- Professional office or home-based services;
- Licensed independent clinical social worker;
- Licensed mental health counselor;
- Licensed nurse mental health clinical specialist; or
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

**Mental Disorder** *(GR-9N 34-065 04 MA)*

An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist, a psychiatric social worker, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

Any one of the following conditions is a mental disorder under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.
- Paranoia and other psychotic disorders.
- Delirium and dementia.
- Affective disorders.
- Eating disorders.
- Post traumatic stress disorders.
- Substance Abuse.
- All other mental disorders not otherwise identified and which are described in the most recent edition of the diagnostic and statistical Manual of Mental Disorders (DSM).

Also included is any other mental condition which requires Medically Necessary treatment.

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Outpatient Services

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**Thirty-One Day Continuation** *(GR-9N 31-015-01 MA)*

Coverage under this plan which terminates in accordance with the prior terms of this section will be continued for 31 more days, subject to the following:

- Termination is not due to discontinuance of the Group Contract, or failure to make any required contributions.
- This plan's benefits will be reduced by any other benefits of like kind for which the person becomes eligible.
- If this plan provides a medical expense benefits conversion privilege the following must be submitted to Aetna within the 31 day period of continuation:
  - Application for the personal policy; and
  - The premium.

This applies unless the person elects any other available continuation.

**Continuation of Coverage for Your Former Spouse**

If your health expense benefit coverage for your dependent spouse would terminate because of divorce or of separate support, you may continue any such coverage in force by continuing premium payments.

Coverage may be continued if the valid decree of dissolution of marriage states that you do not have to provide medical or dental coverage for your former spouse.

Coverage will be continued beyond the first to occur of:

- The date you are no longer covered under this Plan.
- The date dependent coverage is discontinued under this Plan for your Eligible Class.
- The end of the period for which required contributions have been made.
- The end of any period set forth in the valid decree of dissolution of marriage during which you are required to provide medical or dental coverage for your former spouse.
- The date you or your former spouse remarries. In the event of remarriage of the group plan member, the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family plan or issuance of an individual plan.

Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to the divorced or separated spouse at their last known address together with notice of the right to reinstate coverage retroactively to the date of cancellation.

**Continuation of Coverage: Employment Ceases**

If your employment terminates due to involuntary lay-off, you may continue Health Expense Coverage (except Dental Expense Coverage) for you and your dependents for 39 weeks. You must request that your coverage continue within 31 days after it would cease due to involuntary lay-off.

Coverage will cease before the end of the 39 weeks on the first to occur of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.
- The date Health Expense Coverage discontinues for employees of your former employer.
- The end of a period equal to the length of time you were last insured.
Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

**Continuation of Coverage: Plant Closing**

If your employment terminated due to a plant closing or partial closing, you may continue Health Expense Coverage, except Dental Expense Coverage for you and your dependents for 90 days. You must request that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Coverage will cease before the end of the 90 days on the first of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

The following terms are defined by Massachusetts law:

- Plant closing.
- Partial closing.

**Continuation of Coverage for Your Dependents After Your Death**

If you die while covered under any part of this plan, any Health Expense Coverage then in force for your dependents will be continued if:

- Your coverage is not then being continued after your employment has stopped due to involuntary lay-off.
- Such coverage is requested within 31 days after your death.
- Premium payments are made for the coverage.

Your spouse's coverage will cease when your spouse remarries. Any dependent’s coverage, including your spouse's, will end when any one of the following happens:

- The end of the 39 week period right after the date the dependent's coverage would otherwise cease.
- The end of a period equal to the length of time you were last covered.
- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for coverage under this plan or another group plan.
- Dependent coverage ceases under this plan.
- Any required contributions cease.

**Continuation of Coverage for Your Child**

The terms of this Continuation of Coverage apply only to your dependent child:

- who attains the limiting age for eligibility; and
- whose coverage under this Plan would otherwise terminate; and
- who is engaged in an ongoing treatment under this Plan, in accordance with a written treatment plan, for a mental, behavioral, or emotional disorder.
Such child's health expenses coverage, except dental expense coverage, may be continued, if:

- written request for such continuation is made within 31 days of the date coverage terminates; and
- that such request includes the following:
  - an agreement to pay up to 100% of the cost to the plan; and
  - evidence, satisfactory to Aetna, of the existence of such a mental, behavioral, or emotional disorder.

Premium payments must be made.

Coverage will cease on the first to occur of:

- the end of a 36 month period that starts on the date coverage would otherwise terminate (but not before the date a course of treatment for a non-biological mental disorder for children or adolescents under the age of 19, as specified in the treatment plan, is completed); or
- the date the child fails to provide the required proof that the course of treatment is still ongoing; or
- the date the child is eligible for similar benefits under any group plan; or
- the date the child becomes eligible for other coverage under the Group Policy; or
- the date the child fails to make any required contributions; or
- the date health expense coverage under this Plan discontinues for employees of your employer.

Aetna will have the right to require proof of the continuation of the course of treatment. Aetna also has the right to examine your child as often as needed while the course of treatment continues at its own expense. An exam will not be required more often than once each year.

If any coverage being continued ceases, the child may apply for a personal policy in accordance with the Conversion Privilege.

Mark T. Bertolini  
Chairman, Chief Executive Officer, and President  
Aetna Life Insurance Company  
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: President And Trustees Of Bates College
Group Policy No.: GP-869807
Rider: New Jersey ET Medical
Issue Date: June 16, 2015
Effective Date: January 1, 2015

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of New Jersey. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits.

You are only entitled to these benefits, if you are a resident of New Jersey, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Obtaining Coverage for Dependents (GR-9N 29.010.03 NJ)
Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse/civil union partner; or
- Your domestic partner who meets the rules as defined by the State of New Jersey; and
- Your dependent children; and
- Dependent children of your domestic partner.

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.

Civil Union Partner (GR-9N 34.015.02 NJ)
A person who has established a civil union as defined by New Jersey State Law. If applicable, any references under this Booklet-Certificate made to “marriage”, “husband”, “wife”, “family”, “immediate family”, “dependent”, “next of kin”, “widow”, “widower”, “widowed” or another word which in a specific context denotes a marital or spousal relationship, the same shall include a civil union partner. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be treated as a civil union partner under New Jersey law.

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)
Extraterritorial Certificate Rider (GR-9N-CR1)

Policyholder: President And Trustees Of Bates College
Group Policy No.: GP-869807
Rider: New York ET Medical
Issue Date: June 16, 2015
Effective Date: January 1, 2015

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of New York. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of New York, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Payment of Benefits (GR-9N 32-025 01 NY)

Benefits will be paid as soon as the necessary proof to support the claim is received, but not later than: (a) 30 days of receipt of a claim transmitted electronically or via the internet; or (b) 45 days for a claim submitted by other means. Written proof must be provided for all benefits.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider (GR-9N-CR1)
Policyholder: President And Trustees Of Bates College
Group Policy No.: GP-869807
Rider: Rhode Island ET Medical
Issue Date: June 16, 2015
Effective Date: January 1, 2015

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Rhode Island. These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits. You are only entitled to these benefits, if you are a resident of Rhode Island, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Alcoholism, Substance Abuse and Mental Disorders Treatment (GR-9N-S-11-175-01)

Both inpatient and outpatient coverage is available under this plan.

Inpatient Treatment
Covered expenses will include inpatient facility expenses incurred by a person who is confined as an inpatient:

- in a hospital; or
- in a community residential facility.

for treatment of alcoholism or drug abuse. Inpatient facility expenses are charges made by such hospital or facility in connection with:

Services to Detoxify
Not included in any coverage year are charges:

- for more than five (5) detoxification occurrences or thirty (30) days, whichever is met first.

Rehabilitation Services in a hospital
If a person is a full-time inpatient in a hospital, expenses are covered in the same way as those for any other disease.

Rehabilitation Services in a community residential facility
Not included are charges for more than thirty (30) days of confinement in a Calendar Year.

If rehabilitation services, are provided in accordance with a partial confinement treatment program, two (2) treatment sessions will be deemed to be one day of confinement.
A treatment session starts when a person enters the hospital or community residential facility; and ends when the person leaves the facility, and completes one (1) day or night care treatment.

**Outpatient Treatment**

**Covered expenses** will include outpatient facility expenses incurred by a person for treatment of alcoholism or drug abuse rendered:

- in a hospital; or
- in a public or private facility licensed to provide services especially for the rehabilitation of alcoholics or drug abusers.

while not confined in such facility.

If a person is not a full-time inpatient in a hospital: Expenses incurred for medication management are covered the same way as those for any other disease. For any other expenses when a person is not a full-time inpatient in a hospital, no more than thirty (30) special outpatient Calendar Year maximum hours applies to each person.

**Orthotic and Prosthetic Devices and Scalp Hair Protheses**

**Covered expenses** include charges made for orthotic and prosthetic devices. **Covered expenses** also include charges made for a scalp hair prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.

An orthotic device means a custom fabricated brace or support that is designed based on medical necessity. It does not include prefabricated or direct-formed orthotic devices, as defined in this section, or any of the following assistive technology devices: commercially available knee orthoses used following injury or surgery; spastic muscle-tone inhibiting orthoses; upper extremity adaptive equipment; finger splints; hand splints; wrist gauntlets; face masks used following burns; wheelchair seating that is an integral part of the wheelchair and not worn by the patient independent of the wheelchair; fabric or elastic supports; corsets; low-temperature formed plastic splints; trusses; elastic hose; canes; crutches; cervical collars; dental appliances; and other similar devices as determined by the director of the department of health, such as those commonly carried in stock by a pharmacy, department store, corset shop, or surgical supply facility.

A prosthetic device means an artificial limb that is alignable or, in lower-extremity applications, capable of weight bearing. Prosthesis means an artificial medical device that is not surgically implanted and that is used to replace a missing limb, appendage, or other external human body part including an artificial limb, hand, or foot. The term does not include artificial eyes, ears, noses, dental appliances, osotomy products, or devices such as eyelashes or wigs.

Orthotic and prosthetic devices and scalp hair prostheses expenses are payable on the same basis as the most current standards of Medicare. Orthotic and prosthetic devices are limited to the most appropriate model that adequately meets your medical needs as determined by your treating physician. Scalp hair prostheses expenses are subject to a Calendar Year benefit maximum of $350.

**Covered expenses** include repair of an orthotic or prosthetic device. **Covered expenses** also include replacement of an orthotic or 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 plan will not cover expenses and charges for, or expenses related to:

- the repair and replacement of orthotic or prosthetic devices or scalp hair prosthesis necessitated by misuse or loss.
- orthotic and prosthetic devices provided by a vendor or orthotic and prosthetic services rendered by a provider who is not licensed by the state of Rhode Island to provide orthotic and prosthetic devices.

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### Appeals Procedure (GR-9N 32-050 01)

#### Definitions

**Adverse Benefit Determination (Decision):** 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.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is experimental or investigational.
- A decision that the service or supply is not medically necessary.

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

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

**Concurrent Care Claim Extension:** A request to extend a 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.

**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 and 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.

**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
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 72 hours after the claim is made.

If more information is needed to make an urgent claim decision, Aetna will notify the claimant within 72 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.

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.

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 decision for urgent care as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 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 decision 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 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 write Member Services. 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.

Appeals of Adverse Benefit Determinations
You may submit an appeal if Aetna gives notice of an adverse benefit determination. This Plan provides for two levels of appeal depending upon the type of coverage provided under the Plan. A final adverse benefit determination notice will also provide an option to request an External Review (if available).

You have 180 calendar days with respect to Group Health Claims 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.
- 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.

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 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 36 hours of receipt of the request for an appeal.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.
Level Two Appeal
If Aetna 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 a decision 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 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 36 hours of receipt of the request for a Level Two Appeal.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two Appeal.

Post-Service Claims
Aetna 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 Rhode Island Department of Insurance to request an investigation of a complaint or appeal; or
- File a complaint or appeal with the Rhode Island 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 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.
External Review

You may receive an adverse benefit determination or final adverse benefit determination.

In these situations, you may request an External Review if you or your provider disagrees with Aetna's decision.

To request an External Review, any of the following requirements must be met:

- You have received an adverse benefit determination notice by Aetna, and Aetna did not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services.
- You have received a final adverse benefit determination notice of the denial of the claim by Aetna.
- Your claim was denied because Aetna determined that the care was not necessary or appropriate or was experimental or investigational.
- You qualify for a faster review as explained below.
- As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which you are responsible exceeds $500.

The notice of adverse benefit determination or final adverse benefit determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to the U.S. Office of Personnel Management within 123 calendar days of the date you received the adverse benefit determination or final adverse benefit determination notice. You also must include a copy of the notice and all other pertinent information that supports your request.

The U.S. Office of Personnel Management will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO usually within 45 calendar days of Aetna's receipt of your request form and all the necessary information.

A faster review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would:

- Seriously jeopardize your life or health; or
- Jeopardize your ability to regain maximum function; or
- If the adverse benefit determination relates to experimental or investigational treatment, if the physician certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive a faster review if the final adverse benefit determination relates to an admission; availability of care; continued stay; or health service for which you received emergency care, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after Aetna receives the request.

Aetna will abide by the decision of the ERO, except where Aetna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to Aetna. Aetna is responsible for the cost of sending this information to the ERO and for the cost of the external review except for dental, vision and hearing claims.
For more information about the Appeals Procedure or External Review processes, call the Member Services telephone number shown on your ID card.

Mark T. Bertolini  
Chairman, Chief Executive Officer and President  

Aetna Life Insurance Company  
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Amendment
Policyholder: President And Trustees Of Bates College
Group Policy No.: GP-869807
Rider: Texas ET Medical - OC PPO
Issue Date: August 11, 2015
Effective Date: July 1, 2015
Texas: Medical Expense Coverage

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents.

The benefits in this rider are specific to residents of Texas. If the benefits for covered expenses in this rider have no corresponding covered expense in the booklet certificate, then the covered expenses in this rider are in addition to the benefits provided under your booklet certificate. The benefits for covered expenses in this rider replace any benefits for covered expenses for the same benefit in the booklet certificate.

Except as otherwise shown in this rider, the benefits in this rider are subject to the annual limits and overall coverage year maximum (if any) specified in your booklet certificate.
IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Aetna's toll-free telephone number for information or to make a complaint at

1-800-MY-Health (694-3258)

You may also write to Aetna at:

Aetna, Inc.
2777 Stemmons Freeway, Dallas, TX 75207

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

FAX No. (512) 475-1771

Web: http://www.tdi.state.tx.us

E-mail: Consumer Protection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact Aetna first. If the dispute is not resolved you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of your Policy.

AVISOS IMPORTANTES

Para obtener información o para someter una queja:

Usted puede llamar al número de teléfono gratis de Aetna’s para información o para someter una queja al

1-800-MY-Health (694-3258)

Usted también puede escribir a Aetna:

Aetna, Inc.
2777 Stemmons Freeway, Dallas, TX 75207

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos, o quejas llamando al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

FAX No. (512) 475-1771

Web: http://www.tdi.state.tx.us

E-mail: Consumer Protection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMACIONES:
Si surge una disputa su concerniente a prima o a una reclamación, debe comunicarse con Aetna primero. Si no se resuelve la disputa puede comunicarse con el Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA:
Este aviso es sólo para propósito de información y no se convierte en una parte o condición de su Póliza.
You have the right to an adequate network of preferred providers (also known as "network providers").

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

You have the right, in most cases, to obtain estimates in advance:

- from out-of-network providers of what they will charge for their services; and
- from your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: www.aetna.com or by calling 1-800-MY-Health (694-3258) for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website:


Texas Department of Insurance Notice
Important Information About Coverage Under The Texas
Life and Health Insurance
Guaranty Association
(For Insurers Declared Insolvent or Impaired on or After September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (the "Association") administers this protection system. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the Texas Insurance Code, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association
When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at the time (regardless of where the policyholder lived when the policy was issued)
- Residents of other states, ONLY if the following conditions are met:
  1. The policyholder has a policy with a company domiciled in Texas;
  2. The policyholder's state of residence has a similar guaranty association; and
  3. The policyholder is not eligible for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association
Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies; up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.
Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439
www.tdi.state.tx.us
To be eligible, a dependent grandchild must be:

- The unmarried child of your child; and
- Under age 25; and
- Supported by you for Federal Income Tax purposes on the date of his or her initial application for coverage. Coverage will not terminate solely due to the child’s loss of such Federal Income Tax dependency status.

Your children can include the following:

- Your biological children;
- Your stepchildren;
- Your legally adopted children; including any child placed with you for adoption and any child for whom you are a party in a suit in which the adoption of the child is sought;
- Your foster children;
- Any child for whom you or your covered spouse is under court order for medical support. This child is covered immediately upon Aetna’s notification of such order;
- 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.

Special Enrollment Periods

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;
  - 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; or
  - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage;
  - the operation of another Plan’s lifetime maximum on all benefits, if applicable.
  - You or our dependents become eligible for State 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, or you become a party to a suit in which adoption of the dependent is sought; 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 or a child for whom you are a party in a suit in which the adoption of the child is sought.

Your plan will provide coverage for a child who is placed with you for adoption or a child for whom you are a party in a suit in which the adoption of the child is sought if:

• You request coverage for the child within 31 days of the date the child is placed with you or within 31 days of the date on which you became a party to the suit in which the adoption of the child is sought.
• Notice of placement or notice of your participation in the suit in which the adoption of the child is sought will need to be presented to **Aetna** prior to the dependent enrollment.
• Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption or for whom you are a party in a suit for which adoption of the child is sought, if the placement or your participation in the suit occurs before the child attains 18 years of age and the child is enrolled within 31 days of the adoption or placement for adoption, or your participation in said suit.

**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. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent’s life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

• The child meets the plan’s definition of an eligible dependent; and
• You request coverage for the child.

Coverage for the dependent will become effective on the date the employer is given notice of the court order. Any coverage limitations for a pre-existing condition will not apply.
Under a QMCSO or QDRSO, 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.

**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;
- A short-term limited duration coverage plan; and
- The State Children’s Health Insurance Program (S-CHIP).

**Coverage for Emergency Medical Conditions** *(GR-9N-11-035-02-TXET)*

Covered expenses include charges made by a hospital emergency room or Freestanding Emergency Medical Care Facility for services provided to evaluate and treat an emergency medical condition.

The emergency care benefit covers the following when obtained in either a hospital emergency room or a Freestanding Emergency Medical Care Facility:

- Use of the Provider facilities;
- Physicians services;
- Nursing staff services; and
- Radiologists and pathologists services.

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

**Important Reminder**

If you visit a hospital emergency room or a Freestanding Emergency Medical Care Facility 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 or a Freestanding Emergency Medical Care Facility.

**Emergency Care** *(GR-9N-34-025-02-TXET)*

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

**Freestanding Emergency Medical Care Facility** *(GR-9N-34-030-02-TXET)*

A facility appropriately licensed under the Texas Health and Safety Code, that is structurally separate and distinct from a hospital and that receives an individual and provides Emergency Care.

**Urgent Condition** *(GR-9N-34-105-02-TXET)*

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 or in a Freestanding Emergency Medical Care Facility; and

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

**Urgent Care Provider (GR-9N-34-025-02 TXET)**

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.
  - Makes charges.
  - 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 or a Freestanding Emergency Medical Care Facility.

**Routine Cancer Screenings (GR-9N-11-006 TX)**

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

- 1 mammogram every 12 months for covered females age 35 and over;
- Cervical Cancer Screening--For the detection of the human papillomavirus for covered persons age 18 or more: 1 Pap smear; or screening using liquid-based cytology methods, either alone or in conjunction with a test approved by the United States Food and Drug Administration every 12 months.
- 1 gynecological exam every 12 months (this includes a rectovaginal pelvic exam for women age 25 and over who are at risk of ovarian cancer);
- For Detection of Colorectal Cancer --For covered persons who are age 50 or more and deemed to be at normal risk for colon cancer, the following are covered:
  - 1 Fecal occult blood test performed annually; or
  - 1 flexible Sigmoidoscopy every 5 years; or
  - 1 Colonoscopy every 10 years
- For Detection of Prostate Cancer --1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older..

Covered expenses for children from birth to age 6 also include:

- Immunizations and booster doses of all immunizing agents used in child immunizations, including but not limited to immunization against diphtheria; haemophilus influenza type B; Hepatitis B; Hepatitis A measles; mumps; pertussis; polio; rubella; tetanus; varicella and any other immunization that is required for the child by law, which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services or as required by law. No deductible, copayment or coinsurance applies for childhood immunization services.
**Early Detection of Cardiovascular Disease** *(GR-9N-11-080 TX)*

The plan includes coverage for certain tests for the early detection of cardiovascular disease for any covered person who is:

1. male and older than 45 years of age and younger than 76 years of age; or
2. female and older than 55 years of age and younger than 76 years of age;

and who is:

- Diabetic; or
- Has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

If performed by a laboratory that is certified by a national organization recognized by Texas for the purposes of this section, coverage will be provided for one of the following non-invasive screening tests for atherosclerosis and abnormal artery structure and function:

- computed tomography (CT) scanning measuring coronary artery calcification; or
- ultrasonography measuring carotid intima-media thickness and plaque.

**Important Reminder**

Refer to the *Schedule of Benefits* for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for early detection of cardiovascular disease.

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**Treatment of Jaw Joint Disorder** *(GR 9N 11-150 01 TX)*

The plan covers charges made by a **physician**, **hospital** or **surgery center** for the diagnosis and surgical treatment of **jaw joint** disorder if treatment is necessary as a result of an accident, a trauma, a congenital defect, a developmental defect, or pathology. A **jaw joint disorder** is defined as a painful condition:

- Of the jaw joint itself, such as Temporomandibular Joint Dysfunction (TMJ) Syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as Myofacial Pain Dysfunction (MPD).

Benefits are payable up to the **jaw joint disorder** maximum shown in the *Schedule of Benefits*.

Unless specified above, not covered under this benefit are charges for non-surgical treatment of a **jaw joint disorder**.

**Mammograms**

- 1 mammogram every 12 months for covered females age 35 and over.

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**Acquired Brain Injury Coverage** *(GR-9N-11-200-03)*

An “acquired brain injury” is a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

The following services, as defined below, are covered if they are medically necessary as a result of, and related to an acquired brain injury unless such injury was sustained in an activity or occurrence for which other similar coverage under the plan is limited or excluded.

a. **Cognitive rehabilitation therapy**: Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual’s brain-behavioral deficits.
b. Cognitive communication therapy: Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

c. Neurocognitive therapy: Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

d. Neurocognitive rehabilitation: Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

e. Neurobehavioral testing: An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;

f. Neurobehavioral treatment: Interventions that focus on behavior and the variables that control behavior.

g. Neurophysiological testing: An evaluation of the functions of the nervous system.

h. Neurophysiological treatment: Interventions that focus on the functions of the nervous system.

i. Neuropsychological testing: The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

j. Neuropsychological treatment: Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

k. Neurofeedback therapy: Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

l. Remediation: The process(es) of restoring or improving a specific function.

m. Post-acute transition services: Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

n. Post-acute care treatment services: Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

o. Community reintegration services: Services that facilitate the continuum of care as an affected individual transitions into the community.

p. Other similar coverage: The medical/surgical benefits provided under a health benefit plan. This term recognizes a distinction between medical/surgical benefits, which encompass benefits for physical illnesses or injuries, as opposed to benefits for mental/behavioral health under a health benefit plan.

q. Outpatient day treatment services: Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

r. Psychophysiological testing: An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
s. Psychophysiological treatment: Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Coverage will also include outpatient day treatment services, or other post-acute care treatment services.

**Autism Spectrum Disorder Treatment** *(GR-9N 11-080-09 TX)*

Covered dependent children older than two years of age and younger than ten years of age who have been diagnosed with autism spectrum disorder are covered for all generally recognized services prescribed in a treatment plan for autism spectrum disorder by the child’s physician. “Generally recognized services” may include:

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of autism spectrum disorder.

**Clinical Trials** *(GR-9N 11-080-05 TX)*

The plan includes coverage for routine patient care costs in connection with a phase I, phase II, phase III, or phase IV clinical trial, if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

1. the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
2. the National Institutes of Health;
3. the United States Food and Drug Administration;
4. the United States Department of Defense;
5. the United States Department of Veterans Affairs; or
6. an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

“Routine patient care costs” means the costs of any medically necessary covered benefit that would have been covered under the plan even if the covered person had not been participating in a clinical trial.

Routine patient care costs do not include:

- the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
- the cost of a service or supply that is not a medically necessary covered benefit, regardless of whether the service or supply is required in connection with participation in a clinical trial;
- the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- a cost associated with managing a clinical trial; or
- the cost of a service or supply that is specifically excluded from coverage under a plan.

All plan deductibles, coinsurance and copayments that would typically apply under the plan for routine patient care costs will apply when this care is received during the course of a clinical trial.

Limitations:

1. The plan is not required to reimburse the research institution conducting the clinical trial for the cost of routine patient care provided through the research institution unless the research institution, and each health care professional providing routine patient care through the research institution, agrees to accept reimbursement under the plan at either the Negotiated Charge or the Recognized Charge, as appropriate for the particular provider, as payment in full for the routine patient care provided in connection with the clinical trial.
2. The plan will not provide coverage for services and supplies that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.
3. The plan will not provide coverage for routine patient care provided Out-of-Network unless Out-of-Network coverage for such care is otherwise provided under the plan.
4. The plan will not provide coverage for services and supplies provided outside of Texas.

**Mastectomy and Related Procedures** *(GR-9N 11-095-01 TX)*

**Covered expenses** include hospital and physician services related to mastectomy, including the following services in connection with post-mastectomy care:

- Reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction;
- Surgery on a healthy breast to make it symmetrical with the reconstructed;
- Prostheses; and
- Treatment for physical complications at all stages of mastectomy, including lymphedemas.

The following coverage is provided for a covered person following a mastectomy:

1. a minimum of 48 hours of inpatient care in a hospital following a mastectomy;
2. a minimum of 24 hours of inpatient care in a hospital following a lymph node dissection for the treatment of breast cancer.

A shorter length of stay may be requested by the person undergoing the mastectomy if the person's physician and the person together determine the shorter stay to be appropriate.

Coverage is provided for a post-discharge physician office visit or in-home nurse visit within the first 48 hours after a discharge.

Covered expenses are payable on the same basis as for any other medical condition.

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

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

If the mother is requests a shorter postpartum stay, she and the child will be covered for timely post-delivery care. Post-delivery care may be provided to the mother and child by a physician, registered nurse, or other appropriate licensed health care provider and may be provided at the mother's home, a health care provider's office, or a health care facility. Benefits include postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments, including parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care shall be determined in accordance with recognized medical standards for that care. A copayment will not apply for home health care visits.

**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.

Reconstructive or Cosmetic Surgery and Supplies (GR-9N-11-012 TX)

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

- Surgery to correct the result of an accidental injury provided the surgery occurs no more than 24 months after the injury. For a covered child, surgery will be covered up to age 18 or up to 24 months after the injury, whichever period is longer. Injuries that occur during surgical procedures or medical treatments are not considered accidental injuries, even if unplanned or unexpected.
- Surgical implantation or attachment of covered prosthetic devices.
- Surgery to correct a gross anatomical defect present at birth. The surgery will be covered if the purpose of the surgery is to improve function. For a covered child, surgery will be covered up to age 18 to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.
- Other surgery needed for the treatment of an illness. The surgery must be needed to improve function.

Please see also the "Mastectomy and Related Procedures" section of this certificate for more information on that topic.

Important Reminders
For services and supplies involving cleft lip or cleft palate, refer to the Specialized Care section, Treatment of Cleft Lip or Palate for coverage details.

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

Diabetic Equipment, Supplies and Education (GR-9N-11-135 TN)

Covered Medical Expenses include charges for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes. If you are diagnosed with diabetes, coverage will include the following to the extent not already covered under other parts of this coverage:

- The necessary equipment, in accordance with your treatment plan;
- Lab and diagnostic tests;
- Drugs and supplies prescribed by the physician
- Immunizations for influenza and pneumococcus

Specifically, the coverage includes:

a) blood glucose monitors, including those designed to be used by or adapted for the legally blind;
b) test strips specified for use with a corresponding glucose monitor;
c) lancets and lancet devices;
d) visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
e) insulin and insulin analog preparations;
f) injection aids, including devices used to assist with insulin injection and needleless systems;
g) insulin syringes;
h) biohazard disposal containers;
i) insulin pumps, both external and implantable, and associated appurtenances, which include:
   (1) insulin infusion devices;
   (2) batteries;
   (3) skin preparation items;
   (4) adhesive supplies;
(5) infusion sets;
(6) insulin cartridges;
(7) durable and disposable devices to assist in the injection of insulin; and
(8) other required disposable supplies;
j) repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
k) prescription medications which bear the legend Caution: Federal Law prohibits dispensing without a prescription' and medications available without a prescription for controlling the blood sugar level;
l) podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
m) glucagon emergency kits.

Also included as covered expenses are charges for outpatient self-management training for you or your caretaker for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes if prescribed by a licensed health care professional who has the required state authority to prescribe such training.

Outpatient self-management training includes, but is not limited to education and medical nutrition therapy. The training must be provided by a registered or licensed health care professional trained in the care and management of diabetes and authorized to provide such care.

Benefits will be payable for:

- Initial training visits after diagnosis, including but not limited to counseling in nutrition and proper use of equipment and supplies.
- Training and education as a result of a later diagnosis by a physician of a significant change in your symptoms or condition which requires a modification of your self-management program.
- Training and education that is necessary because of the development of new techniques and treatments for diabetes.

If the diabetes self-management training is provided on the written order of a physician or other health care provider, the training must also include a diabetes self-management training program recognized by the American Diabetes Association.

This training must be provided by:

(1) A multidisciplinary team coordinated by either:
   (i) a diabetes educator who is certified by the National Certification Board for Diabetes Educators; or
   (ii) an individual who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies.

The team must consist of at least a licensed dietitian and a registered nurse. A pharmacist and a social worker may also be included. Each member of the team, other than the social worker, must have had recent instructive and practical preparation in diabetes clinical and educational issues as determined by the team member's licensing agency, in consultation with the commissioner of public health.

Otherwise, the team member's licensing agency, in consultation with the commissioner of public health, must have determined that the team member's standard licensing training includes the skills the member needs to provide diabetes self-management training; or

(2) A diabetes educator certified by the National Certification Board for Diabetes Educators.
If not performed as noted above, the diabetes self-management training must include one or more of the following components:

- nutritional counseling provided by a licensed dietitian;
- a pharmaceutical component provided by a pharmacist;
- a component provided by a physician assistant or R.N, except that the physician assistant or registered nurse may not be paid for providing nutritional counseling or a pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or
- a component provided by a physician.

**Orthotic Devices** *(GR-9N-14-085-05 TXET)*

The plan includes coverage for orthotic devices, including custom-fitted or custom-fabricated medical devices that are applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease. The coverage includes the professional services related to the fitting and use of the devices, as well as repair and replacement unless due to misuse by the covered person.

Coverage is limited to the most appropriate model orthotic device that adequately meets the medical needs of the covered person as determined by the covered person’s treating physician, podiatrist or orthotist, and the covered person as applicable.

**Prosthetic Devices**

Prosthetic devices, including breast prostheses, that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects, are covered under the plan. The coverage includes the professional services related to the fitting and use of the devices, as well as repair and replacement unless due to misuse by the covered person. Covered prosthetic appliances include those items covered by Medicare unless specifically excluded under the plan.

Coverage is limited to the most appropriate model prosthetic device that adequately meets the medical needs of the covered person as determined by the covered person’s treating physician or prosthetist, and the covered person, as applicable.

**Amino Acid-Based Elemental Formulas** *(GR-9N-11-022 TX)*

Coverage will be provided for amino acid-based elemental formulas, if your physician has issued a written order stating that an amino acid-based elemental formula is medically necessary for treatment after diagnosis of any of the following diseases or disorders:

- immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- severe food protein-induced enterocolitis syndrome;
- eosinophilic disorders, as evidenced by the results of a biopsy; and
- impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Coverage is provided regardless of the formula delivery method. Coverage includes any medically necessary services associated with the administration of the formula.
Home Health Care (GR-9N-11-050 TX)

Home health care expenses are covered if:

- the charge is made by a home health care agency and the care is given under a home health care plan; and
- the care is given to you in your home; and
- the attending physician certifies that hospitalization or confinement in a skilled nursing facility would be required if a treatment plan for home health care were not provided.

Home health care expenses are charges for:

- Part-time or intermittent care by an R.N., L.P.N., or licensed vocational nurse under the supervision of at least one registered nurse and at least one physician.
- Part-time or intermittent home health aide services for patient care. These services need to be provided during intermittent visits.
- The following:
  - Medical equipment and supplies,
  - Drugs and medicines prescribed by a physician.
  - Lab services provided by or for a home health care agency
  - Medical social services

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 up to 4 hours is one visit.

This maximum will not apply to care given by an R.N., L.P.N., or licensed vocational nurse when:

- Care is needed to transition from the hospital or skilled nursing facility to home care.

When the above criteria is met, covered medical expenses include up to 12 hours of continuous care by an R.N., L.P.N. or licensed vocational nurse 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. Note: Home short-term physical, speech, respiratory, or occupational therapy is covered when the above home health care criteria are met.

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 or your domestic partner's family.
- Services of a certified or licensed social worker.
- Transportation.
- 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 preauthorized by Aetna. Refer to How the Plan Works for details about preauthorization.
Refer to the Schedule of Benefits for details about any applicable home health care visit maximums.

| Maximum Visits per Calendar Year | 120 visits | 120 visits |

**Newborn Hearing Screening, Diagnosis and Treatment (GR.9N-11-015 TX)**

Covered expenses include:

- A screening test, including any related necessary diagnostic follow up care, to determine hearing loss for a newborn child from birth through the date the child is 30 days old.
- **Medically Necessary** diagnosis and treatment for a child from birth through the date the child is 2 years old.

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

| Newborn Screening Test for Hearing Loss and Necessary Follow-up Care Related to Test. | 100% per test | 60% per test |
| No Calendar Year deductible applies. | No Calendar Year deductible applies. |

**Orally Administered Anticancer Medications (GR.9N-11-225-AA01 TX)**

Coverage is provided for orally administered anticancer medications that are used to kill or slow the growth of cancerous cells. Coverage will be provided on a basis that is no less favorable than: (a) intravenously administered or injected cancer medications that are covered as medical benefits by the plan; and (b) other visits for cancer treatment.

**Telemedicine Medical Services and Telehealth Services (GR.9N-11-195 TX)**

The plan will not exclude coverage for a telemedicine medical service or a telehealth service which is covered under the plan solely because the service is not provided through a face-to-face consultation.

The provider who provides or facilitates the use of telemedicine medical services or telehealth services shall ensure that:

- the informed consent of the covered person, or another appropriate person with authority to make health care treatment decisions for the patient, is obtained before telemedicine medical services or telehealth services are provided; and
- the confidentiality of the covered person’s medical information is maintained as required by law.

**Phenylketonuria Treatment (GR.9N-11-210 TX)**

The plan includes coverage for formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as for prescription drugs available only on the orders of a physician.

**Important Information About Covered Prescription Drugs**

**Aetna** utilizes one or more drug **formularies**. A drug **formulary** is a list of prescription drugs and insulin established by Aetna, which includes both **brand name prescription drugs**, and **generic prescription drugs**. This list is subject to periodic review and modification by Aetna, in accordance with applicable state laws.

An Aetna pharmacy committee comprised of providers in active clinical practice from a variety of specialties and from different locations in the United States regularly review available literature and other clinical information on prescription drugs. The Federal Drug Administration (FDA) approved **brand name prescription and generic prescription drugs** chosen for Aetna’s drug **formularies** are selected based on their safety, effectiveness and overall value.
Notification of changes to a drug **formulary** will be provided as required. Drug **formulary** changes will be effective upon the renewal date of your plan. Copies of Aetna’s drug **formularies** are available at any time upon request or they may be accessed at the Aetna pharmacy website, at [www.aetna.com](http://www.aetna.com).

If you are receiving coverage for **prescription drugs** that are removed from the drug **formulary** during the calendar year you will continue to have those **prescription drugs** covered at the same benefit level until your plan’s renewal date.

**Off Label Prescription Drugs**

FDA-approved **prescription drugs** are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information or the American Hospital Formulary Service Drug Information), 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 reviewed journal. Coverage of off-label use of these drugs may, in Aetna’s sole discretion, be subject to **preauthorization** or other plan requirements or limitations. Medical necessity review will not result in denial of payment if the sole reason for denial is that the **prescription drug** is being prescribed for off-label usage. Coverage of off label use of these drugs may, in Aetna’s sole discretion, be subject to **preauthorization**, **step-therapy** or other Aetna requirements or limitations.

**Other Covered Expenses** *(GR-9N-13-005 TX)*

The following **prescription drugs**, medications and supplies are also **covered expenses** under this Coverage.

**Contraceptives**
The following contraceptives and contraceptive devices:

- Oral Contraceptives.
- Diaphragms, 1 per 365 consecutive day period
- Injectable contraceptives.
- Contraceptive patches.
- Contraceptive rings.
- Implantable contraceptives and IUDs are covered when obtained from a **physician**. The **physician** will provide insertion and removal of the drugs or device.

**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 or substance abuse counseling, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse, a mental disorder; or serious mental illness; and
- A physician is not you or related to you.
In no event will the covered amount for Out-Of-Network charges be less than 50% of the covered amount for In-Network charges.

**Coordination of Benefits**

**Getting Started - Important Terms**

When used in this provision, the following words and phrases have the meaning explained herein.

**Allowable Expense** means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, preauthorization of admissions, and preferred provider arrangements.
5. If all plans covering a person are high deductible plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible plan’s deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan’s payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

**Closed Panel Plan(s).** A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

**Custodial Parent.** A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

**Plan.** Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
- Medical benefits coverage in a group, group-type, and individual automobile “no-fault” or other medical payments coverage available under any automobile policy including traditional automobile “fault” type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the policy that provides benefits for health care expenses.

**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.

**Which Plan Pays First** *(GR-9N 33-010 01-TX)*

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, 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); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. **Child Covered Under More than One Plan.** The order of benefits when a child is covered by more than one plan is:
   
   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      
      i. The parents are married or living together whether or not married;
      
      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   
   B. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child’s health care expenses, but that parent’s spouse does, the plan of the parent’s spouse is the primary plan.
   
   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
      
      - The plan of the custodial parent;
      
      - The plan of the spouse of the custodial parent; and then
      
      - The plan of the noncustodial parent.

   For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. **Active Employee or Retired or Laid off Employee.** The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. 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 rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

4. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. 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 rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, subscriber longer is primary.

6. **If the preceding rules do not determine the primary plan,** the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

### Worker’s Compensation

If benefits are paid by Aetna and Aetna determines you received Worker’s 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 Worker’s 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 Worker’s Compensation due to medical or health care is not agreed upon or defined by you or the Worker’s Compensation carrier; or
- The medical or health care benefits were provided to you through this plan but are subsequently excluded from a Worker’s Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this policy, you will notify Aetna of any Worker’s 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.

**Continuing Coverage for Dependents After Your Death**

If you should die while enrolled in this plan, your dependent’s coverage will continue as long as:

- You were covered at the time of your death;
- Your coverage, at the time of your death, is not being continued after your employment has ended;
- A request is made for continued coverage within 60 days after your death; and
- Payment is made for the coverage.

Your dependent’s coverage will end when the first of the following occurs:

- The end of the 36 month period following your death;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop.

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

**Important Note**

Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Medical Insurance Policy* for more information.

**Continuation of Coverage for Your Dependents After Your Retirement**

If coverage for your dependents would terminate because you retire while covered under any part of this plan, any coverage then in force for your dependents may be continued. Continuation must be requested within 60 days after your retirement. Premium payments for the coverage must be continued.

Your dependent’s coverage will not continue beyond the first to occur of:

- The end of a 36 month period starting on the date of your retirement.
- The date a dependent becomes eligible for coverage under any group plan providing health benefits.
- The date dependent coverage under this Plan is discontinued.
- The end of the period for which any required contributions have been made.

If any coverage being continued terminates, the person may apply for a personal policy in accordance with the conversion privilege.

**Continuing Health Care Benefits**
You may continue coverage under the plan which terminates for you and your dependents, for any reason, except involuntary termination of employment due to cause, but only if you have been covered under this plan for at least 3 months in a row prior to such termination.

You must request the continuation in writing within 60 days of the later to occur of:

- the date coverage would otherwise cease; and
- the date your employer or group policy holder provides you with the notice of your right to continue coverage.

Premium payments must be continued. The required contribution for continued coverage may not exceed 102% of the group rate.

Continuation for a person may not terminate until the earliest of:

- 6 months after the date the COBRA continuation has ended, if the person is eligible for COBRA; or
- 9 months after the date the election is made if the person is not eligible for COBRA.
- The end of the period for which required contributions are made.
- The date the person is or could be covered by Medicare.
- The date the person is covered or is eligible for similar benefits under another medical expense plan.
- The date the person has similar benefits available pursuant to any state or federal law, other than COBRA.

Coverage for a dependent will cease earlier when the person:

- ceases to be a defined dependent under this plan; or
- becomes eligible for other coverage under the group contract.

You and your dependents can elect this continuation in lieu of or following any other continuation offered under this plan. If this continuation is elected, the conversion privilege will not be available.

**Handicapped Dependent Children (GR-9N-31015-01 TX)**

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 31 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.
Continuation of Coverage During a Labor Dispute
This continuation of coverage provision only applies if this plan is subject to a collective bargaining agreement.

If your coverage under this plan would cease because you cease work due to a labor dispute, you can arrange to continue your coverage during your absence from work if the Texas Insurance Code applies. Coverage may continue for up to 6 months.

Continuation will cease when the first of these events occurs:

- You fail to make the required payments to your collective bargaining unit representative.
- Your representative fails to make the required premium payments to Aetna.
- You go to work full time for any other employer.
- Any premium due date when less than 75% of the affected employees have elected to continue their coverage.
- The 6 month continuation period ends.

The monthly premium required by Aetna for each person's coverage will be the applicable rate in effect on the date you cease work. Aetna has the right to change premium rates under the terms of this Plan at any time during this continuation of coverage.

Texas Health Insurance Risk Pool
You may be eligible for coverage under the Texas Health Insurance Risk Pool. Not later than 30 days prior to the end of your coverage under any State of Texas continuation, Aetna will provide you with the Texas Health Insurance Risk Pool's address and toll-free telephone number.

Converting to an Individual Medical Insurance Policy

Eligibility
You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical plan because:

- You terminate your employment;
- You are no longer in an eligible class;
- Your dependent no longer qualifies as an eligible dependent;
- Any continuation coverage required under federal or state law has ended; or
- You retire and there is no medical coverage available.

You can only use the conversion option once. If your group plan allows retirees to continue medical coverage, and you wish to continue your plan, then the conversion privilege will not be available to you again.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

Features of the Conversion Policy
The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent’s states of residence; and
- Offered by Aetna when you or your dependents apply under your employer’s conversion plan.

If your group plan was issued after June 1, 1996, your conversion, coverage may not be the same as your group plan coverage. Generally, the coverage level may be less, and there is an applicable overall lifetime maximum benefit. For group plans issued prior to June 1, 1996 your conversion coverage will be the same as your group plan coverage.
The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy.

**Limitations**

You or your dependents do not have a right to convert if:

- Medical coverage under the group contract has been discontinued.
- You or your dependents are eligible for Medicare. Covered dependents not eligible for Medicare may apply for individual coverage even if you are eligible for Medicare.
- Coverage under the plan has been in effect for less than three months.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You or your covered dependents are eligible for, or have benefits available under, another plan that, in addition to the converted policy, would either match benefits or result in over insurance. Examples include:
  - Any other hospital or surgical expense insurance policy;
  - Any hospital service or medical expense indemnity corporation subscriber contract;
  - Any other group contract; or
  - Any statute, welfare plan or program.

**Electing an Individual Conversion Policy**

You or your covered dependents have to apply for the individual policy within 31 days after your coverage ends. You do not need to provide proof of good health if you apply within the 31 day period.

If coverage ends because of retirement, the 31 day application period begins on the date coverage under the group plan actually ends. This applies even if you or your dependents are eligible for benefits based on a disability continuation provision because you or they are totally disabled.

To apply for an individual medical insurance policy:

- Get a copy of the “Notice of Conversion Privilege and Request” form from your employer.
- Complete and send the form to Aetna at the specified address.

**Your Premiums and Payments**

Your first premium payment will be due at the time you submit the conversion application to Aetna.

The amount of the premium will be Aetna’s normal rate for the policy that is approved for issuance in your or your dependent’s state of residence.

**When an Individual Policy Becomes Effective**

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once Aetna receives and processes your completed application and premium payment.
Reimbursement to Texas Department of Human Services

All health expenses payable on behalf of your dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify Aetna in writing that the following applies and you request such direct payment be made:

- the Texas Department of Human Services is paying benefits for your child under the financial and medical assistance service program administered pursuant to the Human Resource Code; and you either
- have possession of or access to the child pursuant to a court order; or
- are not entitled to possession of or access to the child and are required by the court to pay child support.

Mark T. Bertolini
Chairman, Chief Executive Officer and President
The group policy specified above has been amended. The following summarizes the changes in the group policy, and
the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the
date shown above.

The following Appeals Procedure, Exhaustion of Process and External Review provisions replace the same provisions
appearing in your Booklet-Certificate or any amendment or rider issued to you:

**Appeals Procedure**

**Definitions**

**Adverse Benefit Determination (Decision):** A determination by Aetna that the health care services provided or
proposed to be provided to the covered person are not **medically necessary** or appropriate, or are **experimental or
investigational**.

Such adverse benefit determination may be based on, among other things:

- Your eligibility for coverage;
- Coverage determinations, including Plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is experimental or investigational; or
- A decision that the service or supply is not Medically Necessary.

**Appeal:** An oral or written request to Aetna to reconsider an adverse benefit determination.

**Claim Subject to Preauthorization:** Any claim for medical care or treatment that requires approval before the
medical care or treatment is received.

**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 previously approved
course of treatment.

**Experimental or Investigational:** With regard to an adverse benefit determination, this means a service or device
for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment,
service, or device but that is not yet broadly accepted as the prevailing standard of care.

**Final Adverse Benefit Determination:** An adverse benefit determination that has been upheld by Aetna at the
exhaustion of the appeals process.
Post-Service Claim: Any claim that is not a “Claim Subject to Preauthorization.”

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 benefit 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 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.

Time Frames for Adverse Benefit Determination Notifications

If the claim is being denied for post-stabilization care requested by the treating physician or other health care provider following Emergency Medical Care, (an "urgent claim"): Aetna will notify the treating physician or other health care provider within one hour of notification of the request.

If the patient is hospitalized at the time the claim is made (an "urgent claim"): Aetna will make notification by telephone or electronic transmission of a claim decision as soon as possible but not more than one working day after the claim is made. Written notification will be made within three working days.

If more information is needed to make a decision in either of these two circumstances described, above, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the physician to provide Aetna with the information.

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

If the patient is not hospitalized at the time the claim is made:

Aetna will make notification of a claim decision within three working days, in writing, to the provider of record and the patient.

In all other circumstances, other than as described in the sections, above or below:

Aetna will make written notification of an adverse benefit determination within the time appropriate to the circumstances relating to the delivery of the services and to the patient’s condition.

Contents of Notifications
If it is an adverse benefit determination Aetna will send notice of that determination accompanied by the following:

1. the principal reasons for the adverse benefit determination;
2. the clinical basis for the adverse benefit determination;
3. a description of or the source of the criteria used as the guideline in making the adverse benefit determination; and
(4) a description of the procedure for the appeal process, including notice of the covered person’s right to appeal an adverse benefit determination to an independent External Review Organization and of the procedures to obtain that review. If the covered person has a life-threatening condition, you the covered person have the right to an immediate independent External Review. Aetna’s appeal process in this circumstance is not required.

Concurrent Care Claim Extensions, Reductions or Terminations
If a covered person is hospitalized at the time of a request for a Concurrent Care Claim Extension, Aetna will make notification by telephone or electronic transmission of a claim decision of regarding concurrent care claim extension as soon as possible but not more than one working day after the claim is made. Written notification will be made within two working days.

If you file an appeal, coverage under the plan will continue for the previously approved 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.

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

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

Appeals of Adverse Benefit Determinations
You may submit an Appeal if Aetna gives notice of an adverse benefit determination. It will also provide an option to request an external review of the adverse benefit determination. If you choose, another person (an authorized representative) may make the appeal on your behalf by providing written consent to Aetna.

Your appeal may be submitted orally or in writing and should include:

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

Send in your appeal to Member Services at the address shown on your ID Card, or call in your appeal to Member Services using the toll-free telephone number listed on such notice.

Aetna will acknowledge receipt, in writing, of your appeal within 5 working days of receiving it.

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.
Group Health Claims
The review of an appeal of an adverse benefit determination shall be provided by an Aetna physician not involved in making the adverse benefit determination.

Non-Expedited Appeals
(Applies for Claims Subject to Preauthorization and Post-Service Claims)

Claims Subject to Preauthorization
(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 an adverse benefit determination concerning specialty care is upheld upon appeal, the health care provider has 10 working days in which to request, in writing, a specialty review. The adverse benefit determination will be reviewed by a provider in the same or similar specialty as that which is the subject of the adverse benefit determination and the review will be complete within 15 working days of its receipt of the request.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Expedited Appeals
(Applies for Claims for Post-Stabilization Care following an Emergency or for Claims When the Patient is Hospitalized -- May Include Appeals Regarding Concurrent Care Claim Reductions or Terminations of Hospital Stays)

Aetna shall issue a decision on the appeal of an adverse benefit determination for an Urgent Care Claim within a timeframe consistent with the urgency of the condition, procedure or treatment, but in no event in a timeframe exceeding the earlier of 1 working day from the date all information necessary to complete the Appeal has been received by Aetna. If Aetna has provided notice of the decision orally, written notice of the decision will be provided within three calendar days of the oral notification.

If yours is an urgent claim, you may immediately appeal Aetna’s adverse benefit determination to an independent External Review Organization. You are not required to first comply with Aetna’s appeals process. Please see the section entitled “External Independent Review”, below.

External Independent Review
If Aetna has denied a claim for benefits, you may request an external review of your claim if you or your provider disagrees with Aetna’s decision. An external review is a review by an independent physician, selected by an independent External Review Organization, who has expertise in the problem or question involved.

You may request a review by an independent External Review Organization assigned to the appeal by the Texas Department of Insurance for any appeal related to an adverse benefit determination concerning a claim subject to preauthorization involving a decision that the service, supply, or non-formulary drug is experimental or investigational and/or is not medically necessary.

If your adverse benefit determination is for a life-threatening condition, you have the right to have your claim immediately reviewed by an independent External Review Organization. You are not required to exhaust Aetna’s internal appeals processes.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the...
Request for External Review Form, and will follow Aetna’s contractual documents and plan criteria governing the benefits.

**Expedited Reviews**
An expedited review is possible if either (a) or (b), below applies:

(a) You have an urgent claim, as described above. The External Review Organization will inform both you and Aetna of the decision within four business days or fewer, (depending on the urgency of the medical specifics of the case), from the date of receipt of the request for the expedited External Review of the urgent claim. If the External Review Organization provides an oral notification, it must follow that oral communication with a written notice of the decision within 48 hours of the oral notification.

(b) Your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Such expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

Aetna will abide by the decision of the External Review Organization.

Aetna is responsible for the cost of the external review.

For more information about the External Review process, call the toll-free Member Services telephone number shown on your ID card.

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**Important Note:**

If Aetna does not meet all of the appeal timeline requirements outlined above, you are considered to have exhausted the appeal requirements and may proceed with an External Review.

**Exhaustion of Process**

Unless otherwise noted above, you must exhaust the applicable processes of the Appeal Procedure before taking further action.

You may not:

- contact the Texas Department of Insurance to request an investigation of a complaint or Appeal; or
- file a complaint or Appeal with the Texas Department of Insurance; or
- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure:

(1) before the 61st day after the date written proof of loss is filed as required under the policy; or
(2) after the third anniversary of the date on which written proof of loss is required under the policy to be filed.
This amendment makes no other changes to the Group Policy or the Booklet-Certificate.

Mark T. Bertolini  
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company  
(A Stock Company)

Rider: Appeals  
Issue Date: August 11, 2015
Schedule of Benefits

Employer: President and Trustees of Bates College

Group Policy Number: GP-869807

Issue Date: June 16, 2015
Effective Date: January 1, 2015
Schedule: 3A
Cert Base: 3

For: Open Choice (PPO Medical Plan) with HSA

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

PPO Medical Plan

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK Deductible*</th>
<th>OUT-OF-NETWORK Deductible*</th>
<th>Other Health Care Deductible*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year</td>
<td>Individual $1,800</td>
<td>$1,800</td>
<td>$1,800</td>
</tr>
<tr>
<td>Deductible*</td>
<td>Family $3,600</td>
<td>$3,600</td>
<td>$3,600</td>
</tr>
</tbody>
</table>

*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: $3,000.
- For out-of-network expenses: $3,000.

Family Maximum Out of Pocket Limit:

- For network expenses: $6,000.
- For out-of-network expenses: $6,000.

<table>
<thead>
<tr>
<th>Lifetime Maximum Benefit Per Person</th>
<th>Unlimited</th>
<th>Unlimited</th>
<th>Unlimited</th>
</tr>
</thead>
</table>

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles 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 and other health care, unless specifically stated otherwise.

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
<th>OTHER HEALTH CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness Benefits</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Routine Physical Exams</strong></td>
<td>Adults and Children.</td>
<td>100% per exam</td>
<td>80% per exam after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Includes coverage for immunizations.</td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
</tr>
<tr>
<td>Maximum Exams per 12 consecutive months period</td>
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<tr>
<td>Adults, age 18 to 65</td>
<td>1 exam</td>
<td>1 exam</td>
<td>1 exam</td>
</tr>
<tr>
<td>Maximum Exams per 12 consecutive months period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults, age 65 and over</td>
<td>1 exam</td>
<td>1 exam</td>
<td>1 exam</td>
</tr>
<tr>
<td><strong>Well Child Exams</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes coverage for immunizations.</td>
<td>100% per exam</td>
<td>80% per exam after Calendar Year <strong>deductible</strong></td>
<td>80% per exam</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
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<tr>
<td>Maximum Exams</td>
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<td></td>
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<tr>
<td>Under age 3</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>first 12 months of life</td>
<td>7 exams</td>
<td>7 exams</td>
<td>7 exams</td>
</tr>
<tr>
<td>13th-24th months of life</td>
<td>3 exams</td>
<td>3 exams</td>
<td>3 exams</td>
</tr>
<tr>
<td>25th-36th months of life</td>
<td>3 exams</td>
<td>3 exams</td>
<td>3 exams</td>
</tr>
<tr>
<td>Maximum Exams per 12 months</td>
<td></td>
<td></td>
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<tr>
<td>From age 3 to age 18</td>
<td>1 exam</td>
<td>1 exam</td>
<td>1 exam</td>
</tr>
<tr>
<td>Family Planning Services (GR-9N S-10-015-01 ME)</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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<tr>
<td><strong>Routine Gynecological Exam (as recommended by a physician)</strong></td>
<td>100% per exam</td>
<td>80% per exam after Calendar Year deductible</td>
<td>80% per exam</td>
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<tr>
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<td>No Calendar Year deductible applies.</td>
<td>No Calendar Year deductible applies.</td>
<td>No Calendar Year deductible applies.</td>
</tr>
<tr>
<td><strong>Hearing Aid Expenses (GR-9N S-10-080-01 ME)</strong></td>
<td>100% per visit after Calendar Year deductible</td>
<td>100% per visit after Calendar Year deductible</td>
<td>100% per visit after Calendar Year deductible</td>
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<tr>
<td></td>
<td>For a covered person under 19 years of age: The maximum benefit payable is limited to $1,400 per hearing aid, per ear for a 36 month period.</td>
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<td><strong>PLAN FEATURES</strong></td>
<td><strong>NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
<td><strong>OTHER HEALTH CARE</strong></td>
</tr>
<tr>
<td><strong>Routine Cancer Screenings (GR-9N S-10-015-01 ME)</strong></td>
<td><strong>Routine Mammography</strong> For covered females age 40 and over. (Coverage for Routine Mammography will be provided the same as any other Diagnostic X-Rays.)</td>
<td>100% per test</td>
<td>80% per test after Calendar Year deductible</td>
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<td></td>
<td>No Calendar Year deductible applies.</td>
<td>No Calendar Year deductible applies.</td>
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<td></td>
<td>Maximum tests per 12 consecutive month period</td>
<td>1 test</td>
<td>1 test</td>
</tr>
<tr>
<td><strong>Prostate Specific Antigen Test</strong> For covered males age 50 to 72.</td>
<td>100% per visit</td>
<td>80% per visit after Calendar Year deductible</td>
<td>80% per visit</td>
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<td></td>
<td>No Calendar Year deductible applies.</td>
<td>No Calendar Year deductible applies.</td>
<td>No Calendar Year deductible applies.</td>
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<td></td>
<td>Maximum tests per 12 consecutive month period</td>
<td>1 test</td>
<td>1 test</td>
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<tr>
<td>Service</td>
<td>Benefits</td>
<td>Deductible Details</td>
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<td>----------------------------------------</td>
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<tr>
<td><strong>Routine Digital Rectal Exam</strong></td>
<td>100% per visit</td>
<td>No Calendar Year deductible applies.</td>
<td></td>
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<tr>
<td>For covered males age 50 to 72.</td>
<td>80% per visit after Calendar Year deductible</td>
<td>No Calendar Year deductible applies.</td>
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<tr>
<td></td>
<td>80% per visit</td>
<td>No Calendar Year deductible applies.</td>
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<td></td>
<td>Maximum tests per 12 consecutive month period</td>
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<tr>
<td><strong>Routine Pap Smears (as required by a physician)</strong></td>
<td>100% per test</td>
<td>No Calendar Year deductible applies.</td>
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<td></td>
<td>80% per test after Calendar Year deductible</td>
<td>No Calendar Year deductible applies.</td>
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<td></td>
<td>80% per test</td>
<td>No Calendar Year deductible applies.</td>
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<td></td>
<td>Maximum Tests per 12 consecutive month period</td>
<td>1 test</td>
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<tr>
<td><strong>Fecal Occult Blood Test</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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<tr>
<td></td>
<td>Maximum Tests per 12 consecutive month period</td>
<td>1 test</td>
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<td>1 test</td>
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<tr>
<td><strong>Sigmoidoscopy</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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<tr>
<td>Age 50 and over</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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<td></td>
<td>Maximum Tests per 5 consecutive year period</td>
<td>1 test</td>
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<td>1 test</td>
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<td></td>
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<td>1 test</td>
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<tr>
<td><strong>Double Contrast Barium Enema (DCBE)</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
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</tr>
<tr>
<td>Age 50 and over</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum Tests per 5 consecutive year period</td>
<td>1 test</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 test</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 test</td>
<td></td>
</tr>
<tr>
<td><strong>Colonoscopy</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
</tr>
<tr>
<td>age 50 and over</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
</tr>
</tbody>
</table>
### Vision Care (GR-9N-S-10-020-01)

<table>
<thead>
<tr>
<th>Vision Care Feature</th>
<th>Network</th>
<th>Out-Of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examinations (including refraction)</td>
<td>100% per exam</td>
<td>80% per exam after Calendar Year <strong>deductible</strong></td>
<td>80% per exam</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physician Services (GR-9N-S-10-025-01)

<table>
<thead>
<tr>
<th>Physician Services Feature</th>
<th>Network</th>
<th>Out-Of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visits (non-surgical)</td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td>60% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

### Alternative to Physician Office Visit (GR-9N-S-10-025 09)

<table>
<thead>
<tr>
<th>Alternative to Physician Office Visit Feature</th>
<th>Network</th>
<th>Out-Of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-visit Online Consultation by a Physician</td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td>60% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

### Specialist Office Visits

<table>
<thead>
<tr>
<th>Specialist Office Visits Feature</th>
<th>Network</th>
<th>Out-Of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td>60% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Alternative to Specialist Office Visit (GR-9N-S-10-025 01)

<table>
<thead>
<tr>
<th>Alternative to Specialist Office Visit Feature</th>
<th>Network</th>
<th>Out-Of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-visit Online Consultation by a Specialist</td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td>60% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

### Physician Office Visits-Surgery

<table>
<thead>
<tr>
<th>Physician Office Visits-Surgery Feature</th>
<th>Network</th>
<th>Out-Of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td>60% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Physician Services for Inpatient Facility and Hospital Visits

<table>
<thead>
<tr>
<th>Physician Services for Inpatient Facility and Hospital Visits Feature</th>
<th>Network</th>
<th>Out-Of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td>60% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Network Coverage</td>
<td>Out-of-Network Coverage</td>
<td>Other Health Care Coverage</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------</td>
<td>--------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td><strong>Administration of Anesthesia</strong></td>
<td>80% per procedure after Calendar Year <strong>deductible</strong></td>
<td>60% per procedure after Calendar Year <strong>deductible</strong></td>
<td>80% per procedure after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Immunizations</strong> (when not part of the physical exam)</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Prenatal Visits</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
</tbody>
</table>

**PLAN FEATURES**

| Emergency Medical Services (GR-9N 10-030 01) |
|----------------------------------------------|-------------------|-------------------|-------------------|
| **Hospital Emergency Facility and Physician** | 80% per visit after Calendar Year **deductible** | Paid the same as the Network level of benefits. | Paid the same as the Network level of benefits. |

**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 | Not Covered |

**Urgent Care Services**

| Urgent Medical Care (at a non-hospital free standing facility) | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% 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. | 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)*

<table>
<thead>
<tr>
<th></th>
<th>Not Covered</th>
<th>Not Covered</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

### PLAN FEATURES

#### Outpatient Diagnostic and Preoperative Testing *(GR-9N-S-10-035-01)*

| Complex Imaging Services | 80% per test after Calendar Year **deductible** | 60% per test after Calendar Year **deductible** | 80% 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** | 80% per procedure after Calendar Year **deductible** |

#### Diagnostic X-Rays

| Diagnostic X-Rays | 80% per procedure after Calendar Year **deductible** | 60% per procedure after Calendar Year **deductible** | 80% per procedure after Calendar Year **deductible** |

### PLAN FEATURES

#### Network

| Outpatient Surgery *(GR-9N-S-10-040-01)* | 80% per visit/surgical procedure after Calendar Year **deductible** | 60% per visit/surgical procedure after Calendar Year **deductible** | 80% per visit/surgical procedure after Calendar Year **deductible** |

### PLAN FEATURES

#### Network

| Inpatient Facility Expenses *(GR-9N-S-10-45-01)* | 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. | Payable in accordance with the type of expense incurred and the place where service is provided. |

#### Birthing Center

| Hospital Facility Expenses | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |

**Room and Board (including maternity)**

<p>| Other than Room and Board | 80% per admission after Calendar Year <strong>deductible</strong> | 60% per admission after Calendar Year <strong>deductible</strong> | 80% per admission after Calendar Year <strong>deductible</strong> |</p>
<table>
<thead>
<tr>
<th>Skilled Nursing Inpatient Facility</th>
<th>80% per admission after Calendar Year <strong>deductible</strong></th>
<th>60% per admission after Calendar Year <strong>deductible</strong></th>
<th>80% per admission after Calendar Year <strong>deductible</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Days per Calendar Year</td>
<td>100 days</td>
<td>100 days</td>
<td>100 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
<th>OTHER HEALTH CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialty Benefits (GR-9N-10-50-01)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care (Outpatient)</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td>60% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td>Maximum Visits per 365 consecutive days</td>
<td>120 visits</td>
<td>120 visits</td>
<td>120 visits</td>
</tr>
</tbody>
</table>

| **Hospice Benefits** | | | |
| **Hospice Care – Facility Expenses** (Room & Board) | 80% per admission after the Calendar Year **deductible** | 60% per admission after the Calendar Year **deductible** | 80% per admission after the Calendar Year **deductible** |
| **Hospice Care – Other Expenses during a stay** | 80% per admission after the Calendar Year **deductible** | 60% per admission after the Calendar Year **deductible** | 80% per admission after the Calendar Year **deductible** |
| Maximum Benefit per lifetime | Unlimited days | Unlimited days | Unlimited days |

| **Hospice Outpatient Visits** | 80% per visit after the Calendar Year **deductible** | 60% per visit after the Calendar Year **deductible** | 80% per visit after the Calendar Year **deductible** |

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
<th>OTHER HEALTH CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infertility Treatment (GR-9N-S-10-055-01)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic Infertility Expenses</strong> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Comprehensive Infertility Expenses</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Advanced Reproductive Technology (ART) Expenses</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PLAN FEATURES</strong></th>
<th><strong>NETWORK</strong></th>
<th><strong>OUT-OF-NETWORK</strong></th>
<th><strong>OTHER HEALTH CARE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Treatment of Mental Disorders</strong> (GR-9N-S-10-062-01 ME)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MENTAL DISORDERS**

**Hospital Facility Expenses**

<table>
<thead>
<tr>
<th>Room and Board</th>
<th>80% per admission after Calendar Year deductible</th>
<th>60% per admission after Calendar Year deductible</th>
<th>80% per admission after Calendar Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other than Room and Board</td>
<td>80% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
<td>80% per admission after Calendar Year deductible</td>
</tr>
</tbody>
</table>

**Inpatient Residential Treatment Facility Expenses**

<table>
<thead>
<tr>
<th>80% per admission after Calendar Year deductible</th>
<th>60% per admission after Calendar Year deductible</th>
<th>80% per admission after Calendar Year deductible</th>
</tr>
</thead>
</table>

**Outpatient Treatment Of Mental Disorders**

<table>
<thead>
<tr>
<th><strong>Outpatient Services</strong></th>
<th>80% per visit after Calendar Year deductible</th>
<th>60% per visit after Calendar Year deductible</th>
<th>80% per visit after Calendar Year deductible</th>
</tr>
</thead>
</table>
### PLAN FEATURES

#### Inpatient Treatment of Substance Abuse

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Network</th>
<th>Out-of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board</td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
<td>60% per admission after Calendar Year <strong>deductible</strong></td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td>Other than Room and Board</td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
<td>60% per admission after Calendar Year <strong>deductible</strong></td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

#### Inpatient Residential Treatment Facility Expenses

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Network</th>
<th>Out-of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board</td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
<td>60% per admission after Calendar Year <strong>deductible</strong></td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td>Other than Room and Board</td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
<td>60% per admission after Calendar Year <strong>deductible</strong></td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

#### Outpatient Treatment of Substance Abuse

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Network</th>
<th>Out-of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board</td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
<td>60% per admission after Calendar Year <strong>deductible</strong></td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td>Other than Room and Board</td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
<td>60% per admission after Calendar Year <strong>deductible</strong></td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

#### Obesity Treatment Non Surgical (GR-9N-S-10-065-01)

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Network</th>
<th>Out-of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Obesity Treatment (non surgical)</td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td>60% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

#### Obesity Treatment Surgical (GR-9N-S-11-065-01)

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Network</th>
<th>Out-of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
<td>60% per admission after Calendar Year <strong>deductible</strong></td>
<td>80% per admission after Calendar Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Network</th>
<th>Out-of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

#### Transplant Services Facility and Non-Facility Expenses (GR-9N-S-10-075-01)

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Network</th>
<th>Out-of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td><strong>Transplant Facility Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transplant Physician Services (including office visits)</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
</tr>
</tbody>
</table>

### PLAN FEATURES

**Other Covered Health Expenses (GR-9N-S-10-080-01 ME)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Deduction 1</th>
<th>Deduction 2</th>
<th>Deduction 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>80% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Maximum Visits per Calendar Year</strong></td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Ground, Air or Water Ambulance</td>
<td>80% after Calendar Year deductible</td>
<td>80% after Calendar Year deductible</td>
<td>80% after Calendar Year deductible</td>
</tr>
<tr>
<td>Diabetic Equipment, Supplies and Education</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Durable Medical and Surgical Equipment</td>
<td>80% per item after Calendar Year deductible</td>
<td>60% per item after Calendar Year deductible</td>
<td>80% per item after Calendar Year deductible</td>
</tr>
<tr>
<td>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Orthotic and Prosthetic Devices</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Metabolic Formula</td>
<td>80% per prescription or refill after Calendar Year deductible</td>
<td>60% per prescription or refill after Calendar Year deductible</td>
<td>80% per prescription or refill after Calendar Year deductible</td>
</tr>
</tbody>
</table>
### PLAN FEATURES

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
<th>OTHER HEALTH CARE</th>
</tr>
</thead>
</table>

#### Outpatient Therapies *(GR-9N S-10-90-01)*

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Network</th>
<th>Out-of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
</tbody>
</table>

#### Short Term Outpatient Rehabilitation Therapies

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Network</th>
<th>Out-of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Physical, Occupational, and Speech Therapy combined</td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td>60% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

#### Spinal Manipulation

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Network</th>
<th>Out-of-Network</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal Manipulation</td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
<td>60% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

#### Autism Spectrum Disorder *(GR-9N 10-061 02 ME)*

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. Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.
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)

<table>
<thead>
<tr>
<th>PER PRESCRIPTION</th>
<th>COPAY/DEDUCTIBLE</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred Generic Prescription Drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each initial 30 day supply filled at a retail pharmacy</td>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy</td>
<td>$0</td>
<td></td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Preferred Brand-Name Prescription Drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each 30 day supply (retail)</td>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>For more than a 30 day supply but less than a 91 day supply (mail order)</td>
<td>$0</td>
<td></td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Non-Preferred Generic Prescription Drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each 30 day supply (retail)</td>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>For more than a 30 day supply but less than a 91 day supply (mail order)</td>
<td>$0</td>
<td></td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Non-Preferred Brand-Name Prescription Drugs</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>For each initial 30 day supply filled at a retail pharmacy</td>
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<td></td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

Coinsurance

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drug Plan Coinsurance</td>
<td>100% of the negotiated charge</td>
<td>80% of the recognized charge</td>
</tr>
</tbody>
</table>

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.
Expense Provisions (GR-9N S-09-05 01)

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)

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.

Individual Deductible
The Individual deductible is the amount of network or out of network covered expenses you must incur in a Calendar Year before benefits are paid. For purposes of this Plan, an individual means a single covered person enrolled for self only coverage.

Family Deductible
The Family deductible is the amount of network or out of network covered expenses that you and your covered dependents must incur in a Calendar Year before benefits are paid during the Calendar Year for any family members. For purposes of this Plan, a family means a covered person enrolled with one or more dependents. The family deductible can be met by one family member, or a combination of family members.

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.

Copayments and Benefit Deductible Provisions (GR-9N-09-015-01 ME)

Copayment, Copay
This 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.
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 limit applies to both network and out-of-network benefits.

This plan has an Individual and Family Maximum Out-of-Pocket Limit. For purposes of the provision an individual means a person enrolled for self only coverage with no dependent coverage and a Family means a person enrolled with one or more dependents.

Once the amount of eligible expenses you have paid during the Calendar Year meet the Individual Maximum Out-of-Pocket Limit the plan will pay 100% of covered expenses for that person for the remainder of the Calendar Year.

The Family Maximum Out-of-Pocket Limit can be met with a combination of family members or by any single individual within the family. When this limit is reached, your plan will pay 100% of the family's covered expenses for the rest of the Calendar Year.

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 Limit and covered expenses applied to the in-network Maximum Out-of-Pocket Limit 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)

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 the following benefits reduction:

- A $400 benefit reduction will be applied separately to each type of expense.

No penalty will be applied for failure to precertify emergency care.
General (GR-9N 5-28-01 01)

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.
Look back measurement method — standard eligibility language for plans that define full-time employee as 130 hours per month

You and your dependents are eligible for the plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Bates College uses the look-back measurement method to determine whether an employee meets this eligibility threshold.

**New employees hired to work full-time.** If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of the first of the month following 1 month.

**New employees hired to work a variable hour or seasonal schedule.** If you are hired into a part-time position, a position where your hours vary and Bates College is unable to determine — as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months to determine whether you are a full-time employee. Your 12-month IMP will begin on the first of the month following your date of hire and will last for 12 months. If, during your IMP, you average 30 or more hours a week over that 12 month period, you will be full time and, if otherwise eligible for benefits, you will be offered coverage by the first of the second month after your IMP ends. Your full-time status will remain in effect during an associated stability period that will last 12 months from the date that status is determined. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.
**Ongoing employees.** Bates College uses the look-back measurement method to determine group health plan eligibility for ongoing employees. An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period of time over which Bates College counts employee hours to determine which employees work full-time. An employee is deemed full-time if he or she averages 130 or more hours a month over the 12-month standard measurement period. Those employees who average 130 or more hours a month over the 12-month standard measurement period will be full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect for a 12-month stability period. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Bates College uses the standard measurement period and associated stability period annual cycle set forth below.

- **Plan Year:** January 1
- **Measurement Period:** November 1 – October 31
- **Stability Period:** January 1 – December 31