

Summary Plan Description

State of Ohio

Aetna Open AccessTM HMO Plan

July 2010

Welcome!

Our goal is your good health. To achieve this goal, we encourage preventive care in addition to covering you when you are sick or injured. An extensive network of participating physicians and hospitals is available to provide you with easy access to medical care 24 hours a day, 7 days a week.

We believe that through the appropriate use of health resources, we can work together to keep you healthy and to control the rising costs of medical care for everyone.

Your State of Ohio benefits program is an Open Access Health Maintenance Organization (HMO)*. The benefits program is self-funded by your employer and administered by Aetna Life Insurance Company (Aetna).

This Summary Plan Description (SPD) reflects the benefits in effect at the time it was printed. To view changes to the SPD, please access the State of Ohio's benefits website at www.ohio.gov/employeebenefits.

We wish you the best of health.

** As used in this booklet, "HMO" refers to HMO-type benefits that are self-funded by your employer.*

How to Use Your Summary Plan Description

This booklet is your guide to the benefits available through your employer's Open Access HMO Plan. Please read it carefully and refer to it when you need information about how the Plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about many of the special programs available to you as a Plan participant.

If you cannot find the answer to your question(s) in the booklet, call the Member Services toll-free number (800-520-4785) on your ID card. A trained representative will be happy to help you. For more information, go to the "Member Services" section later in this book.

Tips for New Plan Participants

- Keep this booklet where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Post your Primary Care Physician's name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See "In Case of Medical Emergency" for emergency care guidelines.

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How the Plan Works

Plan participants have access to a network of participating Primary Care Physicians (PCPs), specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health.

Primary and Preventive Care

Your PCP can provide preventive care and treat you for illnesses and injuries. The Plan includes coverage for routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP. You are subject to the PCP copay when accessing care from your PCP. Please note that care received from any other network physician is subject to the specialist copay.

Specialty and Facility Care

The Open Access HMO provides you with the freedom to self-refer to any participating provider for medically necessary services. When accessing a specialist or any physician other than your PCP, the specialist copay will apply. Services from nonparticipating providers require prior approval by Aetna.

For some expenses, you must pay a portion of the covered expenses you incur. Your share of covered expenses is called your **coinsurance**. Once your copayments, deductibles and coinsurance amounts (excluding prescription drug copays) reach the **annual out of pocket maximum**, the Plan pays 100% of your covered expenses for the remainder of that plan year.

Provider Information

You may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Member Services number on your ID card.

It is easy to obtain information about providers in Aetna's network using the Internet. With DocFind[®] you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind, go to www.aetna.com/docfind/custom/stateofohio. Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation.

Your ID Card

When you join the Plan, you and each enrolled member of your family receive a member ID card. Your ID card lists the telephone number of the Aetna PCP you have chosen. If you change your PCP, you will automatically receive a new card displaying the change.

Always carry your ID card with you. It identifies you as a Plan participant when you receive services from participating providers or when you receive emergency services at nonparticipating facilities. If your card is lost or stolen, please notify Aetna immediately.

Copayment Schedule

Maximum Benefit	No lifetime maximum
Plan Deductible	
Individual	\$ 200
Family	\$ 400
Annual Out of Pocket Limit	
Individual	\$ 1,500
Family	\$ 3,000
Primary and Preventive Care	
PCP Office Visits	\$ 20 copay (preventive office visit); 20% coinsurance for ancillary services
After Hours/Home Visits/Emergency Visits	\$ 20 copay per visit

Free Exams and Screenings	\$0 Co-Pay Guideline
Well-baby, well-child exam	Various for birth to 2 years; then annual to age 18
Well-person exam (annual physical)	1 per plan year
Hemoglobin, hematocrit, or CBC	1 per plan year
Urinalysis	1 per plan year
Lipid profile or total and HDL cholesterol	1 per plan year
Glucose	1 per plan year
Stool for occult blood	1 per plan year
Pre-natal office visits	As needed; based on physician's ability to code claims separately from other maternity-related services
GYN exam	1 per plan year
Clinical breast exam	1 per plan year
Pap	1 per plan year
Mammogram	1 base line between ages 35-39; 1 per plan year for 40+
PSA	1 per plan year starting at age 40
Flexible sigmoidoscopy	Every 10 years starting at age 50
Colonoscopy	Every 10 years starting at age 50

Copayment Schedule Continued

Free Immunizations	\$0 Co-Pay Guideline
Hepatitis B (HepB)	Birth; 1-2 mos; 6-18 mos
Rotavirus (Rota)	2/4/6 mos
Diphtheria, tetanus, pertussis (DTaP)	2/4/6/15-18 mos; 4-6 yr
Tetanus, diphtheria, pertussis (Td/Tdap)	11-12 yrs; Td booster every 10 yrs, 18 and older
Haemophilus influenzae b (Hib)	2/4/6/12-15 mos
Pneumococcal	2/4/6 mos; 12-15 mos; annually at age 65 and older; high risk groups
Poliovirus (IPV)	2 and 4 mos; 6-18 mos; 4-6 yrs
Influenza	1 per plan year
Measles, mumps, rubella (MMR)	12-15 mos, then at 4-6 yrs; adults who lack immunity
Varicella (Chickenpox)	12-15 mos; 4-6 yrs; 2 doses for adult susceptibles
Hepatitis A (HepA)	2 doses b/w 1-2 yrs
Meningococcal (MCV4)	1 dose between 11-12 years or start of high school or college
Human Papillomavirus (HPV)	3 doses for females age 9 through age 26 years
Zoster (shingles)	1 dose for age 60+

Hearing Aids For natural and accidental hearing loss	50% of the contracted rate Lifetime Maximum: \$ 1,000
Specialty and Outpatient Care	
Specialist Office Visits	\$ 20 copay (preventive office visit); 20% coinsurance for ancillary services
Prenatal Care	\$ 0 copay
Delivery	20% of the contracted rate
Tests and Procedures	20% of the contracted rate per visit
Hearing Exam Covered if medically necessary	\$ 20 copay; 20% coinsurance for ancillary services
Infertility Services	\$ 20 copay plus 20% of the balance of the contracted rate per visit
Basic services to diagnose the underlying cause	per visit
Advanced Reproductive Technology	Not Covered
Allergy Testing	20% of the contracted rate per visit
Allergy Treatment	20% of the contracted rate per visit
Routine injections at PCP's office, with or without physician encounter	
X-rays and Lab Tests	20% of the contracted rate per visit
Complex Imaging Services	20% of the contracted rate per visit
Outpatient Therapy	
Physical and Occupational Therapy combined 30 visit limit per condition per plan year	20% of the contracted rate per visit
Speech Therapy 30 visit limit per condition per plan year	20% of the contracted rate per visit
Chiropractic Care - 20 visit limit per plan year	\$ 20 copay plus 20% of the balance of the contracted rate per visit

Copayment Schedule Continued

Home Health Care	20% of the contracted rate per visit up to 180 visits per plan year
Hospice Care	No copay; No coinsurance
Durable Medical Equipment (DME)	20% of the contracted rate
Prosthetic Devices (including Orthotic supplies)	20% copay - some prostheses must be approved in advance by Aetna
Inpatient Services	
Skilled Nursing Facilities	20% of the contracted rate per visit up to 180 days per plan year; 40% thereafter
Surgery and Anesthesia	
Bariatric Surgery (Morbid Obesity) Covered if medically necessary and you meet the Clinical Policy Bulletins (CPBs) procedures	20% of the contracted rate per visit
Outpatient Surgery	20% of the contracted rate per visit
Emergency Care	
Hospital Emergency Room	\$ 75 copay plus 20% of the balance of the contracted rate per visit
Urgent Care Facility	
Office Visit only	\$ 25 copay
Other Services rendered	20% of the contracted rate per visit
Ambulance	20% of the contracted rate

Your Benefits

Although a specific service may be listed as a covered benefit, it may not be covered unless it is **medically necessary** for the prevention, diagnosis or treatment of your illness or condition. Refer to the “Glossary” section for the definition of “medically necessary.”

Certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval.

Primary and Preventive Care

One of the Plan’s goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan (after any applicable copayment) if provided by participating providers:

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your physician.
- Well-child care from birth, including immunizations and booster doses, as recommended by your physician.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Routine gynecological examinations and Pap smears performed by your PCP. You may also visit a participating gynecologist for a routine GYN exam and Pap smear.
- One baseline mammogram for covered females age 35 to 39. One mammogram every 12 months for covered females age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their PCP.
Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.
- Routine immunizations (except those required for travel or work).
Note: Immunization coverage follows Centers for Disease Control and Prevention guidelines. Health Screenings follow US Preventive Services Task Force recommendations.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services:

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see “In Case of Emergency”).

- Home health services provided by a participating home health care agency, including:
 - skilled nursing services provided or supervised by an RN.
 - services of a home health aide for skilled care.
 - medical social services provided or supervised by a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.
- Outpatient hospice services for a Plan participant who is terminally ill, including:
 - counseling and emotional support.
 - home visits by nurses and social workers.
 - pain management and symptom control.
 - instruction and supervision of a family member.

Note: The Plan does **not** cover the following hospice services:

- bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
- homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
- respite care when the patient's family or usual caretaker cannot, or will not, attend to the patient's needs.
- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, and removal of tumors and odontogenic cysts).
- Accidental dental:
 - 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 Plan Year of the **accident** or in the next Plan 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**.

Covered expenses include charges made for limited services and supplies related to the treatment of teeth, gums, and jaws and their supporting structures, muscles and nerves as follows:

- Impacted teeth. The plan covers oral surgery to remove:
 - Teeth partly or completely impacted in the jawbone;
 - Teeth that will not erupt through the gum; and
 - Other teeth that cannot be removed without removing bone.
- Accidental **injuries** and other trauma. The plan covers oral surgery and related dental services to return sound natural teeth to their pre-trauma functional state, but only if the services take place no later than 24 months after the **injury**.

Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.

- Reconstructive breast surgery following a mastectomy, including:
 - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
 - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
 - physical therapy to treat the complications of the mastectomy, including lymphedema.
- Infertility services to diagnose the underlying medical cause of infertility. You may obtain the following **basic** infertility services from a participating gynecologist or infertility specialist:

- initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
- evaluation of ovulatory function,
- ultrasound of ovaries at an appropriate participating radiology facility,
- postcoital test,
- hysterosalpingogram,
- endometrial biopsy, and
- hysteroscopy.

Semen analysis at an appropriate participating laboratory is covered for male Plan participants.

- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth and/or change in medical status) when approved by Aetna.
- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury. The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:
 - they are needed due to a change in your physical condition, or
 - it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

The request for any type of DME must be made by your physician and coordinated through the Aetna Patient Management Department.

Inpatient Care In a Hospital, Skilled Nursing Facility or Hospice

If you are hospitalized by a participating physician, you receive the benefits listed below, as medically necessary. See “Behavioral Health” for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Intensive or special care facilities when medically necessary.
- Visits by your PCP while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications when necessary.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
 - cardiac rehabilitation, and
 - pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic resonance imaging.
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not

specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Maternity

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may - **after consulting with you** - discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

A list of participating obstetricians can be found in your provider directory or on DocFind (see “Provider Information”).

Note: Your participating obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care after your first visit. They must request approval (precertification) for any tests performed outside of their office and for visits to other specialists. Please verify that the necessary pre-authorization has been obtained before receiving such services.

If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers **on and after your effective date**. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan is your responsibility or that of your previous plan.

Obesity Treatment

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; and
- Diagnostic tests given or ordered during the first exam;

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*.

Behavioral Health

Treatment of mental health disorders and substance abuse is administered by United Behavioral Health. Please refer to the separate booklet for information about the coverage provided by your employer. Mental health and substance abuse treatment is not covered under this Plan.

Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by Aetna.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
 - reconstructive surgery to correct the results of an injury.
 - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
 - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers.
- Custodial care and rest cures.
- Dental care and treatment, except as specified under "Your Benefits". The Plan does not cover:
 - care, filling, removal or replacement of teeth,
 - dental services related to the gums,
 - apicoectomy (dental root resection),
 - orthodontics,
 - root canal treatment,
 - soft tissue impactions,
 - alveolectomy,
 - augmentation and vestibuloplasty treatment of periodontal disease, prosthetic restoration of dental implants, and
 - dental implants. Your Plan may cover dental implants on a case-by-case basis, please contact your Plan Administrator.
- Drugs and medicines which by law need a physician's prescription.
- Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.

Refer to the "Glossary" for a definition of "experimental or investigational."

 - False teeth.
 - Hair analysis.
 - Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Eyeglasses, or contact lenses or the fitting thereof.
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.

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- Hypnotherapy, except when approved in advance by Aetna.
 - Immunizations related to travel or work.
 - Infertility services (but not limited to), except as described under “Your Benefits.” The Plan does not cover:
 - Drugs related to the treatment of non-covered benefits.
 - Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG.
 - Artificial Insemination.
 - 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.
 - ovulation induction and intrauterine insemination services if you are not infertile.
 - Injectable Contraceptives (i.e. depo-provera, IUDs, etc.) if not given during an office visit.
 - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
 - Orthopedic shoes, foot orthotics, or other devices to support the feet, unless necessary to prevent complications of diabetes.
 - Osseous Surgery, if no dental insurance exists or does not cover osseous surgery, such surgery shall be covered as any other surgery. You will need a non-par referral before accessing care.
 - Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, compression stockings/hoses and compression sleeves, and reagent strips.
 - Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
 - Private duty or special nursing care.
 - Radial keratotomy, including related procedures designed to surgically correct refractive errors.
 - Recreational, educational and sleep therapy, including any related diagnostic testing.
 - Religious, marital and sex counseling, including related services and treatment.
 - Reversal of voluntary sterilizations, including related follow-up care.
 - Routine hand and foot care services except for diabetics, including routine reduction of nails, calluses and corns.
 - Routine eye exam
 - Services not covered by the Plan.
 - Services or supplies covered by any automobile insurance policy, up to the policy’s amount of coverage limitation.
 - Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
 - Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
 - obtaining or continuing employment,
 - obtaining or maintaining any license issued by a municipality, state or federal government,
 - securing insurance coverage,
 - travel, and
 - school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.
 - Services and supplies that are not medically necessary.
 - Services you are not legally obligated to pay for in the absence of this coverage.
 - Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.

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- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
 - Specific injectable drugs, including:
 - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,
 - Injectable drugs not considered medically necessary or used for cosmetic, performance, or enhancement purposes, or not specifically covered under this plan,
 - drugs related to treatments not covered by the Plan, and
 - drugs related to the treatment of infertility, and performance-enhancing steroids.
 - 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.
 - Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.
 - Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
 - Therapy or rehabilitation, including (but not limited to):
 - primal therapy.
 - chelation therapy.
 - rolfing.
 - psychodrama.
 - megavitamin therapy.
 - purging.
 - bioenergetic therapy.
 - vision perception training.
 - carbon dioxide therapy.
 - Thermograms and thermography.
 - Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
 - Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
 - Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
 - Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
 - Treatment of injuries sustained while committing a felony.
 - Treatment of mental retardation, defects and deficiencies.
 - Treatment of occupational injuries and occupational diseases, including injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does. If you are covered under a Workers' Compensation law or similar law, and submit proof that you are not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational," regardless of cause.
 - Treatment of spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column.
 - Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
 - treatment performed by placing a prosthesis directly on the teeth,
 - surgical and non-surgical medical and dental services, and
 - diagnostic or therapeutic services related to TMJ.
 - Weight reduction programs except for morbid obesity as described in the booklet and dietary supplements.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance.

In Case of Emergency

Guidelines

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Aetna has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
- *Serious impairment to bodily function; or*
- *Serious dysfunction of any bodily organ or part.*

Some examples of emergencies are:

- Heart attack or suspected heart attack.
- Poisoning.
- Severe shortness of breath.
- Uncontrolled or severe bleeding.
- Suspected overdose of medication.
- Severe burns.
- High fever (especially in infants).
- Loss of consciousness.

Whether you are in or out of Aetna's service area, we ask that you follow the guidelines below when you believe you may need emergency care.

1. Call your PCP first, if possible. Your PCP is required to provide emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility or dial 911 (if your area has this emergency response service).
2. After assessing and stabilizing your condition, the emergency facility should contact your PCP so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your PCP as soon as possible. The emergency room copayment will be waived if you are admitted to the hospital.

Follow-Up Care After Emergencies

You must have approval from Aetna to receive follow-up care from a nonparticipating provider. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain for an urgent medical condition is covered if:

- The service is a covered benefit; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Some examples of urgent medical conditions are:

- Severe vomiting.
- Earaches.
- Sore throat.
- Fever.

Follow-up care provided by your PCP is fully covered, subject to the office visit copayment. Other follow-up care by participating specialists is fully covered at the applicable copay.

What to Do Outside Your Aetna Service Area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings.

If, after reviewing information submitted to Aetna by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an Emergency Room Notification Report or a customer service professional (CSP) can take this information over the telephone.

Special Programs

Member Health Education Programs

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, Aetna's innovative Member Health Education Programs offer health education, preventive care and wellness programs to Plan participants. These programs provide materials that, in conjunction with care and advice from a physician, help promote a healthy lifestyle and good health.

To obtain information on Member Health Education Programs, call the toll-free number on your ID card or visit http://www.aetna.com/products/health_education.html.

Adolescent Immunization

Adolescents need to see their doctors regularly for physical exams and screenings and to update immunizations. To reinforce the importance of protecting their children's health, parents of all 11- and 12-year-olds are sent a newsletter that an examination and immunization schedule recommended for these age groups.

Preventive Reminders

Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats. Each year, Aetna sends a preventive health care reminder to households with a member who is particularly vulnerable to one or more of these diseases - adults who are age 50 and older, children ages 6-23 months, and people over age 2 with a chronic condition such as asthma, congestive heart failure, or chronic renal failure.

The reminder stresses the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screening.

Cancer Screening Programs

Early detection and treatment is important in helping our members lead longer, healthier lives. Member Health Education provides members with an important means of early detection.

Breast Cancer Screening

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease. The mailer may also include information on participating mammography centers or information for women who have chosen a primary care physician with a capitated radiology office. Annually, female members are sent information stressing the importance of annual gynecological exams, direct access to care, as well as instructions on how to perform breast self-examination.

Cervical

Gynecological examinations and Pap smears are vital to women's health because they are often the first step in the detection and treatment of abnormalities. This program reminds female members, starting at 18 years of age, to get exams and Pap smears on a regular basis. Annually, female members are sent information stressing the importance of annual gynecological exams and direct access to care.

Colorectal

The colorectal cancer cure rate can exceed 80 percent when detected early. We encourage you to discuss questions about colorectal cancer screening with your physician. Together you and your physician can choose the most appropriate method of colorectal cancer screening. Aetna sends annual reminders stressing the importance of completing appropriate colorectal cancer screening.

Childhood Immunization Program

Children need immunizations to protect them from a number of dangerous childhood diseases that could have very serious complications. Vaccines have been proven to be powerful tools for preventing certain diseases. It has been shown over time that the risks of serious illness from not vaccinating children far outweigh any risk of reaction to immunization. The common childhood diseases that vaccinations can guard against are:

- Measles
- Mumps
- Rubella
- Polio
- Pertussis (whooping cough)
- Diphtheria
- Tetanus
- Haemophilus influenzae type B
- Hepatitis B
- Varicella (chicken pox)

To promote good health through prevention, the Childhood Immunization Program sends immunization reminders to parents of children covered under this Plan.

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. This reminder contains a list of immunizations recommended at 18 months. *The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing immunizations.

If you have questions about specific vaccinations, please call your pediatrician or your family doctor.

* *Source: Office of Prevention and Health Promotion, in cooperation with the agencies of Public Health Services, U.S. Department of Health and Human Services. Center for Disease Control and Prevention (CDC), American Association of Pediatrics (AAP), and Advisory Committee on Immunization Practices.*

Healthy Insights Member Newsletter

Aetna periodically publishes the *Healthy Insights* newsletter. The newsletter features health-related information, education about various benefits and issues important to quality management and patient management. *Healthy Insights* is an important resource that communicates with Plan participants about a wide variety of topics.

Numbers-to-Know™ .. Hypertension and Cholesterol Management

Aetna created *Numbers To Know™* to promote blood pressure and cholesterol monitoring. The *Numbers To Know* mailer is sent to Plan participants who are targeted by selected diagnoses within specific age groups. The mailer includes helpful tips on blood pressure and cholesterol management; desirable goals for blood pressure and cholesterol; and a tri-fold wallet card to track blood pressure, total cholesterol, medication and dosage information.

Hypertension and high cholesterol are never "cured" but may be controlled with lifestyle changes and adherence to a treatment plan. You can help to stay "heart healthy" by monitoring your blood pressure and blood cholesterol numbers.

Numbers To Know can help encourage you to understand your illness, monitor your high blood pressure and high cholesterol and work with your physician to develop an appropriate treatment plan.

National Medical Excellence Program®

Aetna's National Medical Excellence Program® helps eligible Plan participants access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services.

The program has three components:

- National Transplantation Program, designed to help arrange care for solid organ and bone marrow transplants
- National Special Case Program, developed to coordinate arrangements for treatment of Plan participants with complex conditions at tertiary care facilities across the country when that care is not available within 100 miles of the Plan participant's home
- Out of Country Program, designed for Plan participants who need emergency inpatient medical care while temporarily traveling outside the United States.

If you need a transplant or other specialized care that cannot be provided within the service area, the NME Program will coordinate covered services and will provide the following lodging and travel expenses if you must travel more than 100 miles:

- Transportation expenses you and a companion (if applicable) incur while traveling between your home and the Program facility. Travel expenses incurred by more than one companion are not covered.
- As the NME patient, your lodging expenses incurred while traveling between your home and the National Medical Excellence facility to receive covered services;
- The lodging expenses you incur for lodging away from home to receive covered outpatient services from a NME Program provider;
- The lodging expenses incurred by a companion traveling with you from your home to a National Medical Excellence provider so you can receive covered services; and
- Your companion's lodging expenses when their presence is required to enable you to receive services from a NME Program provider on either an inpatient or outpatient basis. Only the lodging expenses incurred by **one** companion are covered per night.

Benefits for travel and lodging expenses are subject to a maximum of \$10,000 per episode of care. Lodging expenses are subject to a \$50 per night maximum for each person.

Travel and lodging expenses must be approved in advance by Aetna; if you do not receive approval, the expenses are **not** covered.

You become eligible for coverage of travel and lodging expenses on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest to occur of:

- One year after the day a covered procedure was performed;
- The date you cease to receive any services from the Program provider in connection with the covered procedure; or
- The date your coverage terminates under the Plan.

Travel and lodging expenses do not include expenses that are covered under any other part of the Plan.

The Plan covers only those services, supplies and treatments that are considered necessary for your medical condition. Treatment that is considered experimental (as determined by Aetna) is **not** covered by the Plan. Refer to the *Glossary* for a definition of "experimental."

Women's Health Care

Aetna is focused on the unique health care needs of women. They have designed a variety of benefits and programs to promote good health throughout each distinct life stage, and are committed to educating female Plan participants about the lifelong benefits of preventive health care.

Support for Women With Breast Cancer

Aetna's Breast Health Education Center helps women make informed choices when they've been newly-diagnosed with breast cancer. A dedicated breast cancer nurse consultant provides the following services:

- Breast Cancer information
- Second opinion options
- Information about community resources
- Benefit eligibility
- Help with accessing participating providers for:
 - Wigs
 - Lymphedema pumps

Confidential Genetic Testing for Breast and Ovarian Cancers

Aetna covers confidential genetic testing for Plan participants who have never had breast or ovarian cancer, but have a strong familial history of the disease. Screening test results are reported directly to the provider who ordered the test.

Beginning Right Maternity Program

Beginning RightSM Maternity Program offers many benefits. Through an intensive focus on prevention, early treatment and education, the program provides women with the tools to help improve pregnancy outcomes and control maternity-care costs through a variety of services - including risk identification, care coordination by obstetrical nurses and board certified OB/GYNs and Member support.

Eligibility

Employee Eligibility

You are eligible for health care benefits if you are a permanent full-time or permanent part-time employee, which includes established-term regular, established-term irregular, a judge or other elected or appointed official.

State of Ohio employee health plans do not contain pre-existing condition exclusions; therefore, coverage is available to you and your eligible dependents regardless of current health or health history.

Married State Employees

When a husband and wife are both employed by the state, both employees cannot carry family coverage for medical, dental or vision. You have the following options:

- Both may carry single coverage
- Both may be covered by one family plan
- One employee may carry family coverage and the other single, but the spouse with single coverage may not be listed as a dependent under the family plan

Examples of Employees NOT Eligible for Coverage

- Temporary
- Seasonal
- Intermittent
- Interim
- Student or college intern

Dependent Eligibility

Family members as described below may be eligible for coverage under your medical benefits. (Please go to: das.ohio.gov/eligibilityrequirements for the Definitions and Required Documents checklist for documentation required to enroll a dependent.)

1. Spouse. Your current legal spouse as recognized by Ohio law.

2. Unmarried Children under Age 19 including:

- Your biological children
- Your legally adopted children: adopted children have the same coverage as children born to you or your spouse, whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption.
- Your dependent stepchildren: stepchildren must live with you 50% or more of the time
- Foster children who normally reside with you
- Children for whom either you or your spouse has been appointed legal guardian and who normally reside with you
- Children for whom the plan has received a Qualified Medical Child Support order: the child must be named as your alternate recipient in the QMCSO

3. Unmarried Children Age 19 through 22 - Student Status

Your unmarried children age 19 or older, who are attending an accredited school full-time or part-time, are eligible until the end of the month in which they either reach age 23 or cease being a student - whichever occurs first.

Student coverage is not automatic. The State will annually request proof of school enrollment along with a completed Affidavit of Student Status (ADM 4729) form (available at: das.ohio.gov/eligibilityrequirements). When you provide this proof, your dependent will continue to be covered. If the requested proof is not provided to the State, their coverage ends on the last day of their birthday month.

Michelle's Law prohibits health plans from terminating coverage for a dependent child who is a student at a postsecondary institution and who is on a medically necessary leave of absence from school that started July 1, 2010 or later.

To qualify for coverage under this federal provision, the dependent child must be enrolled in the plan, on the basis of student status, immediately prior to the first day of the leave. The leave must begin while the student is suffering from a serious illness or injury, be medically necessary and cause the dependent child to lose student status for purposes of coverage under the plan. Additionally, the student must present written certification from his or her physician indicating that he or she is suffering from a serious illness or injury that necessitates the leave.

Coverage under Michelle's Law continues until either one year after the first day of the medically necessary leave or the day that the student's coverage would have otherwise ended, whichever is earlier.

4. Unmarried Children Incapable of Self-Care

Unmarried children who are incapable of self-support due to mental retardation, severe mental illness, or physical handicap, whose disability began before age 23 and who are primarily dependent upon you are eligible for coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled for coverage, provided that the application is submitted within five (5) years following loss of coverage.

This coverage is not automatic. You must complete the applicable form for this plan. The form can be found at das.ohio.gov/healthplanforms

The form must be completed and sent to this plan no later than 31 days prior to the dependent's 19th birthday, or upon being diagnosed with a disabling condition between the ages of 19 and 23. Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

5. HB1 Child

Ohio House Bill 1 of the 128th General Assembly created a new category of eligibility for the state medical plan. HBI coverage is available for medical (including pharmacy and mental health) coverage only.

HB1 Child requirements:

- Your unmarried child, age 19 through 27, and who is not a student status child aged 19 through 22, as described above; and
- Child is your natural child, stepchild or adopted child; and
- Child is a resident of Ohio or a full time student at an accredited public or private institution of higher education; and
- Child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and
- Child is not eligible for state Medicaid or federal Medicare

A special rate applies for these children.

You can enroll your HB1 Child with the Annual Affidavit of House Bill 1 Child (available at: das.ohio.gov/eligibilityrequirements).

When you enroll your HB1 Child, you must indicate on the applicable form whether the child qualifies as an IRS tax dependent or a child (within the meaning of 26 USC 152(f)(1)) who has not attained age 27 as of the end of the taxable year. You may wish to consult with an independent tax advisor as to your HB1 child's status under the Internal Revenue Code and IRS regulations. If your HB1 child qualifies as an IRS tax dependent or as a child (within the meaning of 26 USC 152(f)(1)) who has not attained age 27 as of the end of the taxable year, the deduction for coverage will occur before adjusted gross income is calculated (pre-tax dollars). If your HB1 child does not meet one of these qualifications, the deduction for coverage will occur after adjusted gross income is calculated.

An employee may enroll or disenroll an HB1 Child during open enrollment, when the child reaches the plan's limiting age, or when a child experiences a change in circumstances. Examples of a change in circumstance

(Ohio Administrative Code 3901-8-13) include moving back to Ohio or the child's loss of employer-sponsored coverage.

To enroll or disenroll an HB1 Child, the employee must notify the State's DAS HCM Customer Service within 30 days of the change in circumstance. You may notify DAS HCM Customer Service by sending an email to dashrd.hcmOAKSsupport@das.state.oh.us or by calling 614.466.8857 or 1.800.409.1205. Upon receiving your request, your child will be offered the opportunity to enroll in HB1 coverage within thirty days. If eligible, coverage will be effective at the beginning of the plan year for open enrollment enrollees, and within 30 days of receiving notice of the election and the required documentation.

Examples of Persons NOT Eligible for Coverage as a Dependent:

- A spouse from whom the employee is legally divorced or legally separated
- Children who are age 28 or older
- A spouse or child currently in the military service, eligible for coverage under a federal health plan
- Married children
- Same-sex partners
- Live-in boyfriends or girlfriends
- Parents or parents-in-law
- Grandchildren (unless employee is the court-appointed legal guardian)
- Adults who are not the employee's or spouse's child under guardianship of employee (brother, sister, aunt, uncle, etc.)
- Common law spouse in which the relationship began in Ohio after October 10, 1991
- A child who is eligible for coverage as an employee of the state or who receives health care coverage through their own employment
- Stepchildren not living with the employee at least 50% of the time
- Any other members of your household who do not meet the definition of an eligible dependent

It is your responsibility to disenroll a family member who is no longer eligible for coverage.

Knowingly providing false or misleading dependent eligibility information may result in any or all of the following actions by the State of Ohio: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible dependents; and/or 4) civil and/or criminal prosecution.

Enrollment

New Employees

When you are first eligible to enroll in the Plan, you will be given enrollment and benefit information. You must complete the enrollment form and return it to your Human Resources representative or online via OAKS within 31 days of the date you become eligible if you wish to participate in the Plan. Coverage will be effective on the first of the month following the date of your hire. If you do not return the form within the 31-day period, your employer will assume that you have waived coverage, and you will not be allowed to participate in the Plan until the next open enrollment period, unless you have a change in status.

Open Enrollment

The annual open enrollment period is your opportunity to review your benefit needs for the upcoming year and to change your benefit elections, if necessary. Open enrollment is typically held each spring, and the elections you make will be in effect July 1 through June 30 of the following calendar year.

Life Events

Under normal circumstances, you cannot change or drop your health benefits coverage unless you experience a qualifying event. Any changes outside of open enrollment must be in compliance with the applicable rules of the Internal Revenue Code Section 125 which may include but not be limited to the following:

1. After marriage, death of a spouse, divorce, legal separation, or annulment, in which case coverage becomes effective the first day of the month following the month of the event.
2. Birth, adoption, placement for adoption, or death of a dependent, in which case coverage becomes effective with the birth, adoption, or placement of a child or date of death.
3. Termination or commencement of employment by the employee, spouse or dependent, in which case coverage becomes effective the first day of the month following the month of the event.
4. Reduction or increase in hours of employment by the employee (including layoff or reinstatement from layoff), spouse, or dependent, including a switch between part-time and full-time, strike, lockout, or commencement, return to work from an unpaid absence, or change in work site in which case coverage becomes effective the first day of the month following the month of the event.
5. Return to work through order of arbitration or settlement of a grievance, or any administrative body with authority to order the return to work of an employee.
6. The employee's dependent satisfies or fails to satisfy the requirement of the definition of dependent due to attainment of age, student status or any similar circumstance as provided in the Health Plan under which the employee receives coverage.
7. If the plan receives a Qualified Medical Child Support Order (QMCSO) pertaining to an employee's dependent, the employee may elect to add or drop the child to the plan depending upon the requirement of the QMCSO.
8. If an employee, spouse, or dependent who is enrolled in a health plan becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).
9. If an employee, spouse, or dependent is no longer entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

Requests for changes pursuant to Sections (1) through (9) must be supported by proper documentation. Documentation must be submitted within 31 days of the event.

10. An employee may change health plans if the employee either no longer resides or no longer works in the service area of the employee's current health plan.

When Coverage Ends

Termination of Employee Coverage

Your coverage will end if:

- You voluntarily terminate coverage during Open Enrollment or due to a Qualifying Event;
- Your employment terminates;
- You are no longer eligible for coverage;
- You do not make the required contributions;
- You become covered under another health care plan offered by your employer; or
- The Plan is discontinued.

Termination of Dependent Coverage

Coverage for your dependents will end if:

- Your coverage ends for any of the reasons listed above;
- You die;
- Your dependent is no longer eligible for coverage; or
- Dependent coverage is no longer available under the Plan.

Family and Medical Leave

If your employer grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by your employer to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, your employer may recover from you the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is terminated because of your gross misconduct, you will not be eligible for COBRA continued coverage.

COBRA Continuation of Coverage

You and your dependents have the right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue medical coverage under certain circumstances (called “qualifying events”) when you would otherwise lose coverage. To do so, you must pay up to 102% of the full regular cost of coverage.

Continuation of Coverage Following Termination of Employment or Loss of Eligibility

You and your covered family members are eligible to continue coverage for up to 18 months if:

- You leave your employer for any reason other than gross misconduct; or
- You are no longer eligible because your working hours are reduced.

You may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue their own coverage.

If you or your dependent is disabled, as defined by the Social Security Administration, at the time of the qualifying event or becomes disabled within 60 days of the event, you may be entitled to an extra 11 months of coverage, for a total of 29 months. You must notify your Human Resources representative of the disability before the end of the original 18-month period to receive the extension, and you must pay up to 150% of the full cost of coverage for every month after the 18th month. Coverage may be continued for the disabled individual and for any family member for whom coverage is already being continued under COBRA, as well as for your newborn or newly adopted child who was added after the date COBRA continuation began. COBRA continuation of benefits will end on the first day of the month that begins more than 30 days after the final determination under Title II or XVI of the Social Security Act that the disabled individual is no longer disabled.

Continuation of Coverage Due to Other Qualifying Events

Your eligible dependents can continue coverage for up to 36 months if coverage would otherwise cease because:

- You die;
- You are divorced;
- You stop making contributions for a spouse from whom you are legally separated;
- You become entitled to Medicare; or
- A covered child is no longer eligible under the Plan.

If one of the above events occurs while you or a covered dependent have already continued coverage due to the termination of your employment or your loss of eligibility, your dependent may extend coverage beyond the original 18-month continuation period, but for no more than a total of 36 months from the date coverage would originally have ended.

Applying for COBRA Continuation

Your Human Resources representative will give you information about how to continue COBRA coverage at the time you become eligible.

You must inform your employer of any status changes that would make your dependents eligible for COBRA coverage within 60 days of the later to occur of:

- The occurrence of the event; and
- The date coverage would terminate due to the event.

To ensure that there is no break in coverage, the election to continue coverage must be made within 60 days of:

- The date coverage would terminate due to the event; or
- The date your employer informs your dependents of their right to continue coverage;

whichever happens later.

If you do not make your election within 60 days, you will lose your COBRA continuation rights.

When COBRA Continuation Coverage Ends

Continuation coverage will end on the earliest date that:

- The COBRA continuation period expires.
- You or your family members do not make the required contributions.
- You or your family members become covered under another group health plan, unless that plan contains a provision that restricts the payment of benefits for a pre-existing condition. Once the pre-existing condition clause of the new plan ceases to apply, your COBRA coverage will cease.
- You or your family members become enrolled in Medicare. (Coverage could continue for those individuals not eligible for Medicare for up to 36 months from the original qualifying event, provided those family members otherwise remain eligible.)
- Your employer terminates this health plan.

Portability of Coverage

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your employer will give you a certificate confirming your participation in the Plan when your employment terminates. Aetna will assist your employer with the preparation and distribution of the certificates.

Conversion From Group to Individual Membership

Most Plan participants who terminate employment or cease to be eligible for benefits may convert to individual membership without evidence of good health if their place of residence remains within the Aetna service area. If you have been continuously enrolled in the Plan for three months, you and/or your eligible dependent may apply to Aetna for a conversion policy within 31 days after:

- Termination of employment.
- Loss of group membership.
- Loss of dependent status.
- Termination of any continuation coverage required under federal or state law.

The converted coverage will not provide the same benefits as your employer's HMO Plan. The rate you pay will be the premium charged for individual policies.

For necessary forms and information about the conversion plan, call the toll-free number on your ID card.

Note: Certain benefits cannot be converted.

Claims

Coordination of Benefits

If you have coverage under other group plans, the benefits from the other plans will be taken into account if you have a claim. This may mean a reduction in benefits under the Plan.

Benefits available through other group plans and/or no-fault automobile coverage will be coordinated with the Plan. "Other group plans" include any other plan of medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured; and
- "No-fault" and traditional "fault" auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law.

To find out if benefits under the Plan will be reduced, Aetna must first determine which plan pays benefits first. The determination of which plan pays first is made as follows:

- The plan without a coordination of benefits (COB) provision determines its benefits before the plan that has such a provision.
- The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent. If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows:
 - The plan that covers the person as a dependent of a working spouse will pay first;
 - Medicare will pay second; and
 - The plan that covers the person as a retired employee will pay third.
- Except for children of divorced or separated parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first. When both parents' birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan doesn't have the parent birthday rule, the other plan's COB rule applies.
- When the parents of a dependent child are divorced or separated:
 - If there is a court decree which states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the parent birthday rule, immediately above, applies.
 - If a court decree gives financial responsibility for the child's medical, dental or other health care expenses to one of the parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent.
 - If there is no such court decree, the order of benefits will be determined as follows:
 - the plan of the natural parent with whom the child resides,
 - the plan of the stepparent with whom the child resides,
 - the plan of the natural parent with whom the child does not reside, or
 - the plan of the stepparent with whom the child does not reside.
- If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.
- The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.
- If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

If it is determined that the other plan pays first, the benefits paid under this Plan will be reduced. Aetna will calculate this reduced amount as follows:

- The amount normally reimbursed for covered benefits under this Plan,
Less
- Benefits payable from your other plan(s).

If your other plan(s) provides benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

Subrogation and Right of Recovery Provision

Definitions

As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

Subrogation

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the Plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover

from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The Plan reserves the right to notify the Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

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

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Exclusion

This Plan does not cover services and supplies, in the opinion of the Claims Administrator or its authorized representative, that are associated with injuries, illness, or conditions suffered due to the acts or omissions of a third party.

Claim Procedures

A claim occurs whenever a Plan participant requests:

- An authorization or referral from a participating provider or Aetna; or
- Payment for items or services received.

Because you are a participant in an HMO-type plan, you do not need to submit a claim for most of your covered healthcare expenses. However, if you receive a bill for covered services, the bill must be submitted promptly to Aetna for payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card.

Aetna will make a decision on your claim. For **concurrent care** claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive written notice if Aetna makes an **adverse benefit determination**.

Adverse benefit determinations are decisions Aetna makes that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:
 - it is not included in the list of covered benefits,
 - it is specifically excluded,
 - a Plan limitation has been reached, or
 - it is not medically necessary.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown below. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see “Complaints and Appeals” for more information about appeals.

Type of Claim	Response Time
<p>Urgent care claim: a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment. 	As soon as possible but not later than 72 hours
<p>Pre-service claim: a claim for a benefit that requires Aetna’s approval of the benefit in advance of obtaining medical care.</p>	15 calendar days
<p>Concurrent care claim extension: a request to extend a previously approved course of treatment.</p>	<p>Urgent care claim - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment</p> <p>Other claims - 15 calendar days</p>
<p>Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.</p>	With enough advance notice to allow the Plan participant to appeal.
<p>Post-service claim: a claim for a benefit that is not a pre-service claim.</p>	30 calendar days

Extensions of Time Frames

The time periods described in the chart may be extended.

For urgent care claims: If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided.

For non-urgent pre-service and post-service claims: The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

If an extension is necessary because Aetna needs more information to process your post service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you fail to provide the information, your claim will be denied.

Grievances and Appeals

The Plan has procedures for you to follow if you are dissatisfied with a decision that Aetna has made or with the operation of the Plan. The process depends on the type of complaint you have. There are two categories of complaints:

- Quality of care or operational issues; and
- Adverse benefit determinations.

Complaints about quality of care or operational issues are called **grievances**. Complaints about adverse benefit determinations are called **appeals**.

Grievances

Quality of care or operational issues arise if you are dissatisfied with the service received from Aetna or want to complain about a participating provider. To make a complaint about a quality of care or operational issue (called a grievance), call or write to Member Services within 30 days of the incident. 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 decision within 30 calendar days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will specify what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

Aetna will send you written notice of an **adverse benefit determination**. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made in writing within 180 days from the receipt of the notice. Your request for appeal can be mailed to:

Aetna Life Insurance Company
Attn: National Accounts CRT
P.O. Box 14463
Lexington, KY 40512

However, appeals of adverse benefit determinations involving urgent care may be made orally.

The Plan provides for two levels of appeal, plus an option to seek external review of the adverse benefit determination. You must complete the two levels of appeal before bringing a lawsuit against the plan. If you are dissatisfied with the outcome of your level one appeal and wish to file a level two appeal, your appeal must be filed no later than 60 days following receipt of the level one notice of adverse benefit determination. The following chart summarizes some information about how appeals are handled for different types of claims.

Type of Claim	Level One Appeal: Response Time From Receipt of Appeal	Level Two Appeal: Response Time From Receipt of Appeal
<p>Urgent care claim: a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment. 	<p>36 hours</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>	<p>36 hours</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>
<p>Pre-service claim: a claim for a benefit that requires approval of the benefit in advance of obtaining medical care.</p>	<p>15 calendar days</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>	<p>15 calendar days</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>
<p>Concurrent care claim extension: a request to extend a previously approved course of treatment.</p>	<p>Treated like an urgent care claim or a pre-service claim, depending on the circumstances</p>	<p>Treated like an urgent care claim or a pre-service claim, depending on the circumstances</p>
<p>Post-service claim: a claim for a benefit that is not a pre-service claim.</p>	<p>30 calendar days</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>	<p>30 calendar days</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

Depending on the type of appeal, you and/or an authorized representative may attend the Level Two appeal hearing and question the representative of the Plan and any other witnesses, and present your case. The hearing will be informal. You may bring your physician or other experts to testify. The Plan also has the right to present witnesses.

If the Plan's appeals process upholds the original adverse benefit determination, you may have the right to pursue an external review of your claim. See "External Review" for more information.

Exhaustion of Process

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:

- contact the Department of Insurance to request an investigation of a complaint or appeal; or
- file a complaint or appeal with the Department of Insurance; or
- establish any:
 - litigation; or
 - 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.

Voluntary Appeals

You may file a voluntary appeal after the standard appeal process has been exhausted. The voluntary appeal should be made to your employer.

You must complete all levels of the standard appeal process, including your appeal for external review when your claim qualifies (see "External Review" below), before you can appeal to your employer. You, or your authorized representative, must request the voluntary level of review within 60 days after you receive the final denial notice under the standard appeal process.

If you file a voluntary appeal, any applicable statute of limitations will be tolled (suspended) while the appeal is pending. Since this level of appeal is voluntary, you are not required to pursue it before initiating legal action.

You must submit your voluntary appeal to your employer in writing, and include the following information:

- the reason for the appeal,
- copies of all past correspondence with Aetna (including your Explanation of Benefits), and
- any applicable information that you have not yet sent to Aetna.

Your employer has the right to obtain information from Aetna that is relevant to your claim.

Your employer will review your appeal and make a decision within 60 days after you file your appeal. If your employer's reviewer needs more time, the reviewer may take an additional 60 day period. You will be notified in advance of this extension.

Your employer's reviewer will notify you of the final decision on your appeal electronically or in writing. The notice will give you the reason for the decision and the Plan provisions upon which the decision was based.

All decisions by your employer will be final and binding.

External Review

You may file a voluntary appeal for external review of any final appeal determination that qualifies.

You must complete the two levels of appeal described above before you can appeal for external review. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal. You must request this voluntary level of review within 60 days after you receive the final denial notice.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

An external review is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials and denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment. You may request a review by an external review organization (ERO) if:

- You have received notice of the denial of a claim; and
- Your claim was denied because 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 Plan appeal process.

The final claim denial letter you receive 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 Aetna within 60 calendar days of the date you received the final claim denial letter. The form must be accompanied by a copy of the final claim denial letter and all other pertinent information that supports your request.

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 rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the Request for External Review Form, and will follow the applicable plan's contractual documents and plan criteria governing the benefits. You will generally be notified of the decision of the External Review Organization within 30 days of Aetna's receipt of your request form and all necessary information. An expedited review is available if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within 3-5 calendar days after Aetna receives the request.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization.

Claim Fiduciary

Claim decisions are made by the Claim Fiduciary in accordance with the provisions of the Plan. The Claim Fiduciary has complete authority to review denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its fiduciary responsibility, the Claim Fiduciary has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

The Claim Fiduciary has the right to adopt reasonable policies, procedures, rules, and interpretations of the Plan to promote orderly and efficient administration. The Claim Fiduciary may not act arbitrarily and capriciously, which would be an abuse of its discretionary authority.

The Plan provides for two standard levels of appeal for adverse benefit determinations. Aetna is the Claim Fiduciary who will provide full and fair review for these appeals.

The Plan also provides two types of voluntary appeals: external review and review by your employer. Aetna is the Claim Fiduciary for external review and your employer is Claim Fiduciary for its review.

Member Services

Member Services Department

Customer service professionals (CSPs) are trained to answer your questions and to assist you in using the Plan properly and efficiently.

Call the Member Services toll-free number on your ID card to:

- Ask questions about benefits and coverage;
- Notify Aetna of changes in your name or telephone number; or
- Notify Aetna about an emergency.

Please call your PCP's office directly with questions about appointments, hours of service or medical matters.

Internet Access

You can access Aetna on the internet at <http://www.aetnastateohioemployee.com> to conduct business with the Member Services department electronically.

When you visit the Member Services site, you can:

- Find answers to common questions;
- Order a new ID card; or
- Contact the Member Services department with questions.

Please be sure to include your ID number, Social Security number and e-mail address.

InteliHealth®

InteliHealth is Aetna's online health information affiliate. It was established in 1996 and is one of the most complete consumer health information networks ever assembled. Through this unique program, Plan participants have access, via the Internet, to the wisdom and experience of some of the world's top medical professionals in the field today. Access InteliHealth through the Aetna Internet website home page or directly via www.intelihealth.com.

Aetna Navigator™

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from InteliHealth®. Access Aetna Navigator™ through the Aetna website home page or directly via www.aetn navigator.com.

With Aetna Navigator, you can:

- Print instant eligibility information
- Request a replacement ID card
- Select a physician who participates in the Aetna network
- Check the status of a claim
- Link to a voluntary Health Risk Assessment tool
- Use the hospital comparison tool to compare hospital outcome information for medical care provided by hospitals in your area
- Estimate the cost of common health care services
- Receive personalized health and benefits messages
- Contact Aetna Member Services

Clinical Policy Bulletins

Aetna uses Clinical Policy Bulletins (CPBs) as a guide when making clinical determinations about health care coverage. CPBs are written on selected clinical issues, especially addressing new technologies, new treatment approaches, and procedures. The CPBs are posted on Aetna's website at www.aetna.com.

Rights and Responsibilities

Your Rights and Responsibilities

As a Plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan.
- Obtain primary and preventive care from the PCP you chose from the Plan's network.
- Change your PCP to another available PCP who participates in the Aetna network.
- Obtain covered care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your PCP or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit our website at www.aetna.com/stateohioemployee. Select DocFind from the drop-down menu under Quick Tools, then under "How do I learn more about:" select the type of plan you're enrolled in.
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered, and any applicable limitations or exclusions.
- Get information about copayments and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

As a Plan participant, you have the responsibility to:

- Choose a PCP from the Plan's network and form an ongoing patient-doctor relationship.
- Help your doctor make decisions about your health care.
- Tell your PCP if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your ID card to providers before getting care from them.
- Pay the copayments and coinsurance required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments and what services are covered and what services are not covered.

Federal Notices

This section describes laws and plan provisions that apply to reproductive and women's health issues.

The Newborns' and Mothers' Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay to less than 48 hours following a vaginal delivery and less than 96 hours following a caesarean section. However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that plan benefits may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

The Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, this Plan covers the follow procedures for a person receiving benefits for an **appropriate** mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

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

For answers to questions about the plan's coverage of mastectomies and reconstructive surgery, call Aetna's Member Services at the number shown on your ID card.

Plan Information

Amendment or Termination of the Plan

Your employer has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified.

The establishment of an employee benefits plan does not imply that employment is guaranteed for any period of time or that any employee receives any nonforfeitable right to continued participation in any benefits plan.

Plan Documents

This plan description covers the major features of the HMO Plan administered by Aetna Life Insurance Company, effective July 1, 2010. The plan description has been designed to provide a clear and understandable summary of the Plan.

Glossary

Annual out-of-pocket maximum - means the maximum amount a Plan participant must pay toward covered expenses in a plan year. Once you reach your annual out-of-pocket maximum, the Plan pays 100% of covered expenses for the remainder of the plan year. Copays, deductibles and coinsurance amounts apply toward the annual out-of-pocket maximum.

Certain expenses do **not** apply toward the annual out-of-pocket maximum:

- Charges for services that are not covered by the Plan.
- Copayments for prescription drugs.

Coinsurance - means the sharing of certain covered expenses by the Plan and the Plan participant. For example, if the Plan covers an expense at 80% (the Plan's coinsurance), your coinsurance share is 20%.

Companion - means a person whose presence as a companion or caregiver is necessary to enable a National Medical Excellence (NME) patient to:

- Receive services from an NME Program provider on an inpatient or outpatient basis; or
- Travel to and from an NME Program provider to receive covered services.

Copayment (copay) - means the fee that must be paid by a Plan participant to a participating provider at the time of service for certain covered expenses and benefits, as described in the "Copayment Schedule."

Cosmetic surgery - means any surgery or procedure that is not medically necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not:

- Restore bodily function;
- Correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or
- Correct or naturally improve a physiological function.

Covered services and supplies (covered expenses) - means the types of medically necessary services and supplies described in "Your Benefits."

Custodial care - means any service or supply, including room and board, which:

- Is furnished mainly to help you meet your routine daily needs; or
- Can be furnished by someone who has no professional health care training or skills; or
- Is at a level such that you have reached the maximum level of physical or mental function and are not likely to make further significant progress.

Deductible - means the part of your **covered expenses** you pay before the plan starts to pay benefits.

Detoxification - means the process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.

Durable medical equipment - means equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Emergency - means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

With respect to emergency services furnished in a hospital emergency department, the Plan does not require prior authorization for such services if you arrive at the emergency medical department with symptoms that reasonably suggest an emergency condition, based on the judgment of a prudent layperson, regardless of whether the hospital is a participating provider. All medically necessary procedures performed during the evaluation (triage and treatment of an emergency medical condition) are covered by the Plan.

Employer - means the State of Ohio.

Experimental or investigational - means services or supplies that are determined by Aetna to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval 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 for research purposes; or
- The written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes.

Home health services - means those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by Aetna.

Hospice care - means a program of care that is:

- Provided by a hospital, skilled nursing facility, hospice or duly licensed hospice care agency;
- Approved by Aetna; and
- Focused on palliative rather than curative treatment for a Plan participant who has a medical condition and a prognosis of less than 6 months to live.

Hospital - means an institution rendering inpatient and outpatient services, accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation or specialty institution.

Infertility - means:

- For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.
- For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

Inpatient - means a person who is confined in a hospital.

Medical services - means those professional services of physicians or other health professionals, including medical, surgical, diagnostic, therapeutic and preventive services authorized by Aetna.

Medically necessary - means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the "Your Benefits" section of this booklet. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining whether a service or supply is medically necessary, Aetna will consider:

- Information provided on your health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered medically necessary:

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting; or
- Experimental services and supplies, as determined by Aetna.

Mental or nervous condition - means a condition which manifests signs and/or symptoms that are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited to:

- Psychosis;
- Affective disorders;
- Anxiety disorders;
- Personality disorders;
- Obsessive-compulsive disorders;
- Attention disorders with or without hyperactivity; and
- Other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

Morbid Obesity - 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.

NME patient - means a person who:

- Requires any National Medical Excellence procedure or treatment covered by the Plan;
- Is approved by Aetna as an NME patient; and
- Agrees to have the procedure or treatment performed in a facility designated by Aetna as the most appropriate facility.

Outpatient - means:

- A Plan participant who is registered at a practitioner's office or recognized health care facility, but not as an inpatient; or
- Services and supplies provided in such a setting.

Partial hospitalization - means medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be provided in a hospital or non-hospital facility that is licensed as an alcohol, drug abuse or mental illness treatment program by the appropriate regulatory authority.

Participating provider - means a provider that has entered into a contractual agreement with Aetna to provide services to Plan participants.

Physician - means a duly licensed member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where they practice, and who provides medical services which are within the scope of their license or certificate.

Plan - means the Open Access Health Maintenance Organization (HMO) which is self-funded by your employer and administered by Aetna Life Insurance Company (Aetna).

Plan benefits - means the medical services, hospital services, and other services and care to which a Plan participant is entitled, as described in this booklet.

Plan participant - means an employee or covered dependent.

Primary Care Physician (PCP) - means a participating physician who supervises, coordinates, and provides initial care and basic medical services as a general or family care practitioner or, in some cases, as an internist or a pediatrician, to Plan participants; maintains continuity of patient care.

Provider - means a physician, health professional, hospital, skilled nursing facility, home health agency, or other recognized entity or person licensed to provide hospital or medical services to Plan participants.

Service area - means the geographic area, established by Aetna and approved by the appropriate regulatory authority, in which a Plan participant must live or work or otherwise meet the eligibility requirements in order to be eligible as a participant in the Plan.

Skilled nursing facility - means an institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist - means a physician who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

Terminal illness - means an illness of a Plan participant, which has been diagnosed by a physician and for which they have a prognosis of six (6) months or less to live.

Urgent medical condition - means a medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP.

All services, plans and benefits are subject to and governed by the terms (including exclusions and limitations) of the agreement between Aetna Life Insurance Company and your employer. The information herein is believed accurate as of the date of publication and is subject to change without notice.