

*Your
Group
Plan*

The McClatchy Company

Routine Care Plan

Table of Contents

Summary of Coverage	1
Your Health Benefits	16
Your Primary Care Physician	16
Primary and Preventive Care	16
Prescription Drug Expense Coverage	16
Special Comprehensive Medical Coverage	19
General Exclusions	37
Effect of Benefits Under Other Plans	40
Coordination of Benefits - Other Plans Not Including	
Medicare	40
Effect of Medicare	43
General Information About Your Coverage	45
Glossary	50
(Defines the Terms Shown in Bold Type in the Text of This Document.)	

The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") or any of its affiliates but will be paid from the Employer's funds. Aetna and its HMO affiliates will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the Customer.

ASA: 620229
Booklet Base: 1A - Routine Care Plan
Issue Date: September 19, 2007
Effective Date: January 1, 2008

Summary of Coverage

Employer: The McClatchy Company
ASA: 620229
SOC: 1A - Routine Care Plan
Issue Date: September 19, 2007
Effective Date: January 1, 2008

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

Eligibility

Employees

To be an eligible employee under this plan, you must:

- be an active employee who is paid on a regular basis through your Employer's payroll system;
- regularly work the minimum number of hours required by your Employer for benefit eligibility;
- complete any benefit waiting period required by your Employer.

Your Eligibility Date, if you are in an Eligible Class as of the Effective Date of this Plan, is the Effective Date of this Plan. Otherwise, it is the date you are considered eligible to receive benefits as determined by your Employer.

You can remain in an Eligible Class as a retired employee if when you terminate active employee status you:

- were employed by an Employer who offers this plan as a retiree health benefit; and
- you meet the age and service requirements of your Employer.

If you are a retired employee in an Eligible Class, you may continue your Health Benefits Coverage and any coverage you have for your dependents.

If you retired before the Effective Date of this Plan, you may also be in an Eligible Class, if you currently have Health Benefits Coverage for you and your dependents. You must follow the Enrollment Procedure.

Dependents

You may cover your:

- legal spouse;
- qualified domestic partner;
- unmarried child(ren) who are under 19 years of age; and
- unmarried child(ren) under age 24 who go to school on a regular basis, are enrolled in a minimum of 12 units undergraduate or 6 units graduate school, and who depend solely on you for support.

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren.
- Children of your qualified domestic partner.
- Any other child you support who lives with you in a qualified parent-child relationship

If you have completed and signed a "Declaration of Domestic Partnership" and the Declaration is acceptable to your Employer, you may also cover as your dependent the person who is the "domestic partner" named in your Declaration.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

In order for a qualified dependent to enroll in the plan, the eligible employee must be enrolled. All qualified children must be enrolled in the same benefit coverage.

Enrollment Procedure

Initial Enrollment

To become covered under this Plan, you must request enrollment during the Initial Enrollment Period for yourself and any eligible dependents you wish to cover. The Initial Enrollment Period starts on your Eligibility Date and ends 31 days later.

Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details. If you are eligible for any coverage as a retired employee, your Employer will advise you concerning the method and amount of any required contributions.

Late Enrollment

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

You must enroll before the end of the next late entrant enrollment period.

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

Special Enrollment Periods

A person, including yourself, will not be considered to be a **Late Enrollee** if all of the following are met:

- You did not elect Health Expense Coverage for yourself or any eligible dependent during the Initial Enrollment Period (or during a subsequent late enrollment period) because at that time:
 - i. the person was covered under another group health plan or other health insurance coverage; and
 - ii. you stated, in writing, at the time you refused coverage that the reason for the refusal was because the person had such coverage, but such written statement is required only if your Employer requires the statement and gives you notice of the requirement; and

the person loses such coverage because:

- i. it was provided under a COBRA continuation provision, and coverage under that provision was exhausted; or
 - ii. it was not provided under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of:
 - legal separation or divorce;
 - death;
 - termination of employment;
 - reduction in the number of hours of employment;
 - the employer's decision to stop offering the group health plan to the Eligible Class to which the employee belongs;
 - cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
 - the operation of another Plan's lifetime maximum on all benefits, if applicable; or
 - iii. employer contributions toward the coverage were terminated.
- You elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

In addition, you and any eligible dependents will not be considered to be **Late Enrollees** if your Employer offers multiple health benefit plans and you elect a different plan during the open enrollment period.

Also, the following persons will not be considered to be **Late Enrollees** given any of the following circumstances:

- You, if you are eligible, but not enrolled, and your newly acquired dependents through marriage, birth, adoption, or placement for adoption. However, you must request enrollment for your newly acquired dependent(s) and yourself, if you are not already enrolled, within 31 days of the marriage, birth, adoption, or placement for adoption.
- Your spouse from whom you are separated or divorced, or child who would meet the definition of a dependent, if you are subject to a court order requiring you to provide health expense coverage for such spouse or child. However, you must request enrollment within 31 days of the court order.

Coverage will be effective:

- i. in the case of marriage, on the first of the month following receipt of the election;
- ii. in the case of a newborn, on the date of birth;
- iii. in the case of adoption, on the date of the child's placement for adoption, or the date the employee or spouse has the right to control the child's health care;
- iv. in the case of court ordered coverage of a spouse or child, on the first of the month following the court order;
- v. in the case of loss of coverage under COBRA continuation, on the first of the month following the election; and
- vi. in the case of loss of coverage for other reasons, on the first of the month following the election.

Effective Date of Coverage

Employees

For eligible employees, coverage will begin as of 12:01 a.m. on the effective date established by the Employer.

If you don't enroll within 31 days of your Eligibility Date, coverage will take effect as provided in the Late Enrollment section of this Summary of Coverage.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage.

You should report any newly acquired dependents. This may affect your contributions. You may request enrollment for yourself and your dependents within 31 days from the date of the qualifying event: marriage, birth, or placement for adoption. The effective date will depend on how you acquire your dependent:

- 1) for marriage, the effective date will be the first day of the first month following receipt of the marriage certificate;
- 2) for birth, the effective date will be the date of birth (birth certificate will be required);

- 3) for adoption, the effective date will be the date the child is placed for adoption, or the date the employee or spouse has the right to control the child's health care;
- 4) for qualified court orders, coverage will become effective on the first of the month following presentation of a qualified court order.

If any dependent is considered a **Late Enrollee**, coverage will take effect on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for such dependent.

Note: This Plan will not pay a benefit for Covered Medical Expenses incurred by a newborn child during the first 31 days of life, unless the child is or becomes enrolled under the Plan within 31 days of the birth.

If the child is enrolled under the Plan within 31 days, contributions will be taken from the effective date of coverage. The Continuation of Coverage under Federal Law provision will not apply.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you request coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption, or the date the employee or spouse has the right to control the child's health care. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Health Benefits

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

Note: As described in the definition of “reasonable charge” in the Glossary, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate payable in certain circumstances for a service or supply.

Prescription Drug Expense Coverage

Prescription Drug Benefits

Payment Percentage

100% as to:

Retail Preferred Pharmacy

Generic Drugs

Copay per Prescription or Refill

after a \$ 15 copay per prescription or refill for each 30 day supply

Brand Name Drugs

On Medication Formulary

after 20% of cost per prescription or refill for each 30 day supply (\$25 minimum; \$75 maximum)

Not on Medication Formulary

after 40% of cost per prescription or refill for each 30 day supply (\$50 minimum; \$125 maximum)

Mail Order Preferred Pharmacy

Generic Drugs

Copay per Prescription or Refill

after a \$ 30 copay per prescription or refill for each supply of up to 90 days

Brand Name Drugs

On Medication Formulary

after 20% of cost per prescription or refill for each supply of up to 90 days (\$50 minimum; \$150 maximum)

Not on Medication Formulary

after 40% of cost per prescription or refill for each supply of up to 90 days (\$100 minimum; \$250 maximum)

Note: There is no benefit for any **prescription drugs** obtained from a non-preferred **pharmacy**.

Your Health Benefits

Note: You may select a **Primary Care Physician** to assist you in managing your health care when you use **Preferred Care Providers**. While you are not required to do so, you are encouraged to select a **Primary Care Physician** so you have the opportunity to work with one physician who can coordinate all of your health care needs. Your **Primary Care Physician**, if selected, coordinates your medical care, except care for the treatment of alcoholism, drug abuse, or a mental disorder. The Aetna Managed Behavioral Health Care Coordinator (AMBHCC) coordinates your medical care for the treatment of alcoholism, drug abuse, and a mental disorder.

In order for the preferred level of inpatient alcoholism, drug abuse, and mental disorder benefits under your Special Comprehensive Medical Expense Coverage to apply to medical care:

- You must contact the AMBHCC, at the number shown on your ID card, before you receive any care for the treatment of alcoholism, drug abuse, or a mental disorder and you must follow the treatment which is recommended and approved by the AMBHCC.

Exceptions:

- Contact with the AMBHCC may take place after inpatient medical care is given to treat an "emergency condition" or an "urgent condition", as defined in your Booklet. You must make this contact as soon as possible after the initial treatment.

All maximums included in this Plan are combined maximums between **Preferred Care** and **Non-Preferred Care**, where applicable, unless specifically stated otherwise.

Certification Requirements

You must obtain certification for certain types of **Non-Preferred Care** to avoid a reduction in benefits paid for that care. Read the Special Comprehensive Medical Coverage section of the Booklet for details of the types of care affected, how to get certification and the effect on your benefits for failure to obtain certification.

Certification for out-of-network **Hospital Admissions, Residential Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Skilled Nursing Care** is required.

Excluded Amount \$ 250

This Excluded Amount applies separately to each type of expense listed above.

Deductible and Copay Amounts

Individual Calendar Year Deductible

Preferred Care	\$ 500
Non-Preferred Care	\$ 1,000

Family Calendar Year Deductible

Preferred Care	\$ 1,500
Non-Preferred Care	\$ 3,000

Individual Calendar Year Deductible Maximum

When Covered Medical Expenses for **Preferred Care** are applied against a person's Calendar Year Deductible in any calendar year equal \$ 500, the Calendar Year Deductible will not apply to **preferred care** during the rest of that calendar year. Covered Medical Expenses incurred during the rest of that calendar year for **preferred care** will not be applied against the person's Calendar Year Deductible.

When Covered Medical Expenses for **Non-Preferred Care** are applied against a person's Calendar Year Deductible in any calendar year equal \$ 1,000, the Calendar Year Deductible will not apply to **non-preferred care** during the rest of that calendar year. Covered Medical Expenses incurred during the rest of that calendar year for **non-preferred care** will not be applied against the person's Calendar Year Deductible.

Family Calendar Year Deductible Maximum

When Covered Medical Expenses for **Preferred Care** are applied against the family Calendar Year Deductible in any calendar year equal \$ 1,500, the Family Calendar Year Deductible will not apply to **preferred care** during the rest of that calendar year. Covered Medical Expenses incurred during the rest of that calendar year for **preferred care** will not be applied against the family's Calendar Year Deductible.

When Covered Medical Expenses for **Non-Preferred Care** are applied against a family's Calendar Year Deductible in any calendar year equal \$ 3,000, the Family Calendar Year Deductible will not apply to **non-preferred care** during the rest of that calendar year. Covered Medical Expenses incurred during the rest of that calendar year for **non-preferred care** will not be applied against the family's Calendar Year Deductible.

Inpatient Facility Admission	
Preferred Care Copay	\$ 500
Non-Preferred Care Copay	\$ 1,000

The Benefits Payable

After any applicable deductible or copay amount, the Health Benefits paid under this Plan in a calendar year are paid at the Coinsurance Rate or Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet.

If any expense is covered under one type of Covered Medical expense, it cannot be covered under any other type.

Coinsurance Rate or Payment Percentage

The Coinsurance Rate or Payment Percentage applies after any deductible or copay amounts.

*The coinsurance rate or payment percentage for **non-preferred care** is based on a reasonable and prevailing rate. Charges that exceed that rate are the employee's responsibility.*

*The coinsurance rate or payment percentage for **non-preferred** Emergency Room and care is based on the billed amount.*

	Preferred Care	Non-Preferred Care
--	---------------------------	-------------------------------

For Emergency Room Treatment - Emergency Care

Payment Percentage	70% after \$75 Copay and Calendar Year Deductible (<i>Copay waived if confined</i>)	70% after \$75 Copay and Calendar Year Deductible (<i>Copay waived if confined</i>)
--------------------	--	--

For Emergency Room Treatment - Non-Emergency Care

No Coverage	No Coverage
-------------	-------------

**Hospital Expenses -
Inpatient Coverage**

Benefit Payable	70% after \$500 Inpatient Facility Admission Copay*	30% after \$1,000 Inpatient Facility Admission Copay*
-----------------	---	---

** Per Inpatient Facility Admission Copay may be applied 3 times per Calendar Year. Applies only once to all hospital or treatment facility stays separated by less than 10 days. Does not apply to Hospice or Skilled Nursing Facilities.*

	Preferred Care	Non-Preferred Care
--	---------------------------	-------------------------------

For Outpatient Hospital Expenses (including surgery)

Payment Percentage	70% after Calendar Year Deductible	30% after Calendar Year Deductible
--------------------	--	---------------------------------------

For Use of Urgent Care Provider

Payment Percentage	100% after a \$ 35 copay	30% after Calendar Year Deductible
--------------------	-----------------------------	---------------------------------------

Ambulance Expenses

Payment Percentage	70% after Calendar Year Deductible	70% after Calendar Year Deductible
--------------------	--	---------------------------------------

Physician Fees (Non-Specialist)*

*Includes in-office Lab
and X-Ray*

Payment Percentage	100% after a \$ 20 copay	30% after Calendar Year Deductible
--------------------	-----------------------------	---------------------------------------

* Includes services of an internist, general physician, family practitioner or pediatrician.

Physician Fees (Specialist)

*Includes in-office Lab
and X-Ray*

Payment Percentage	100% after a \$ 35 copay	30% after Calendar Year Deductible
--------------------	-----------------------------	---------------------------------------

Physician Fees for Routine Hearing Exams (1 exam per 24 months)

Payment Percentage	100% Copay Waived	100% Calendar Year Deductible Waived
--------------------	----------------------	--

Hearing Aids**

Payment Percentage	70% after Calendar Year Deductible	30% after Calendar Year Deductible
--------------------	--	---------------------------------------

** See Benefit Maximums.

	Preferred Care	Non-Preferred Care
--	---------------------------	-------------------------------

Routine Physical Exams

Routine Adult Physical Exams including immunizations

Payment Percentage	100%	100%
	Copay waived	Calendar Year Deductible waived

Routine GYN Exams (one visit per calendar year - includes Pap smear and related lab fees)

Payment Percentage	100%	100%
	Copay waived	Calendar Year Deductible waived

Routine Child Exams* including immunizations

Payment Percentage	100%	100%
	Copay waived	Calendar Year Deductible waived

*If charges made by a physician in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section.

Routine Cancer Screening Expenses (includes routine rectal exam/prostate-specific antigen test for covered males age 40 and over and colorectal cancer screening for all members age 50 and over)

Benefit Payable	100%	100%
	Copay waived	Calendar Year Deductible waived

Routine Mammogram Expenses for covered females age 40 and over

Payment Percentage	100%	100%
	Copay waived	Calendar Year Deductible waived

Other Covered Medical Expenses

Convalescent Facility Expenses

Payment Percentage	70% after Calendar Year Deductible	30% after Calendar Year Deductible
--------------------	--	--

	Preferred Care	Non-Preferred Care
Home Health Care Expenses		
Payment Percentage	70% after Calendar Year Deductible	30% after Calendar Year Deductible
Private Duty Nursing Expenses		
Payment Percentage	70% after Calendar Year Deductible	30% after Calendar Year Deductible
Skilled Nursing Care Expenses		
Payment Percentage	70% after Calendar Year Deductible	30% after Calendar Year Deductible
Hospice Care Expenses		
Inpatient Care	70% after Calendar Year Deductible	30% after Calendar Year Deductible
Outpatient Care	70% after Calendar Year Deductible	30% after Calendar Year Deductible
Short-Term Rehabilitation Expenses <i>(includes physical, speech, and occupational therapy, neurodevelopmental therapy for children under age 6, and massage therapy/naturopathic therapy)</i>	100% after a \$ 35 copay	30% after Calendar Year Deductible
Spinal Disorder Expenses		
Payment Percentage	100% after a \$ 35 copay	30% after Calendar Year Deductible
Second Surgical Opinion Expenses		
Payment Percentage	100% after Office Visit or Specialist copay	30% after Calendar Year Deductible

	Preferred Care	Non-Preferred Care
Durable Medical and Surgical Equipment	70% after Calendar Year Deductible	30% after Calendar Year Deductible
Infertility Treatment Expenses (diagnosis and treatment of the underlying medical condition)	70% after Calendar Year Deductible	30% after Calendar Year Deductible
Allergy Testing		
Payment Percentage	100% after Office Visit or Specialist copay	30% after Calendar Year Deductible
Allergy Treatment - Serum and Injections		
Payment Percentage	70% after Calendar Year Deductible	30% after Calendar Year Deductible
Acupuncture Expenses		
Payment Percentage	100% after Office Visit or Specialist copay	30% after Calendar Year Deductible
<i>For Comprehensive Infertility Expenses</i>		
Payment Percentage	No Coverage	No Coverage
<i>For Bariatric Surgery Expenses*</i>		
Payment Percentage	50% after Calendar Year Deductible and \$500 Inpatient Facility Admission Copay	No Coverage
* See Benefit Maximums.		
<i>For Transplant Expenses</i>		
Payment Percentage	70% after Calendar Year Deductible	30% after Calendar Year Deductible; or covered at 70% if at an IOE Facility
<i>For Advanced Reproductive Technology Expenses</i>		
Payment Percentage	No Coverage	No Coverage

	Preferred Care	Non-Preferred Care
--	---------------------------	-------------------------------

For Family Planning Expenses

Vasectomy, Tubal	70% after	30% after
Ligation and Voluntary	Calendar Year	Calendar Year
Abortion	Deductible	Deductible

Diagnostic Laboratory and X-Ray Expenses

Payment Percentage	70% after	30% after
	Calendar Year	Calendar Year
	Deductible	Deductible

Exception: If the covered person receives the diagnostic X-ray services during a **physician's** office visit, the member will only be responsible for the deductible and coinsurance for the **physician's** office visit.

All Other Covered Medical Expenses for which a Payment Percentage is not otherwise shown	70%	30%
--	-----	-----

Payment Percentage and Special Maximums

National Medical Excellence Travel and Lodging Expenses	100% (Deductible waived)
--	--------------------------

	Preferred Care	Non-Preferred Care
--	---------------------------	-------------------------------

***Alcoholism,
Drug Abuse, and
Mental Disorders
Expenses***

Inpatient Treatment (includes Residential Treatment Facility) - <i>(subject to calendar year maximum days)</i>	70% after Calendar Year Deductible and \$500 Inpatient Facility Admission Copay	30% after Calendar Year Deductible and \$1,000 Inpatient Facility Admission Copay
Outpatient Treatment - <i>(subject to calendar year maximum visits)</i>	100% after \$35 copay	30% after Calendar Year Deductible
Inpatient Calendar Year Maximum	45 days	45 days

Inpatient Calendar Year Maximum Days for treatment of Alcoholism, Drug Abuse and Mental Disorders, for both **Preferred** and **Non-Preferred Care** are combined.

	Preferred Care	Non-Preferred Care
Outpatient Calendar Year Maximum	40 visits	20 visits*

* Outpatient **Non-Preferred Care** Calendar Year Maximum Visits for treatment of Alcoholism, Drug Abuse and Mental Disorders apply to the **Preferred Care** Calendar Year Maximum Visits for a total Calendar Year Maximum of 40 visits.

Payment Limits

These limits apply to Covered Medical Expenses except:

- Expenses which are payable at 50%.
- Expenses applied against any deductible or copay amount.
- Expenses which are payable at a reduced rate because of a failure to obtain any necessary certification.
- Expenses in excess of the allowed or negotiated amount.
- Out-of-network Transplant Expenses.

Coinsurance or Payment Limits which Apply to Expenses for a Person

When a person's **Preferred Care** Covered Medical Expenses for which no benefits are paid because the Payment Percentage reaches \$ 5,000 in a calendar year, benefits will be payable at 100% for all his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for **Non-Preferred Care**.

When a person's **Non-Preferred Care** Covered Medical Expenses for which no benefits are paid because the Payment Percentage reaches \$ 10,000 in a calendar year, benefits will be payable at 100% for all his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for **Preferred Care**.

Coinsurance or Payment Limits which Apply to Expenses for a Family

When a family's **Preferred Care** Covered Medical Expenses for which no benefits are paid because the Payment Percentage reaches \$ 10,000 in a calendar year, benefits will be payable at 100% for all their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for **Non-Preferred Care**.

When a family's **Non-Preferred Care** Covered Medical Expenses for which no benefits are paid because the Payment Percentage reaches \$ 20,000 in a calendar year, benefits will be payable at 100% for all their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for **Preferred Care**.

Benefit Maximums

(Read the coverage section in your Booklet for a complete description of the benefits available. All maximums are combined for Preferred and Non-Preferred services.)

Acupuncture Expenses Maximum Visits	12 per calendar year
Convalescent Days	100 per calendar year
Private Duty Nursing Care Maximum Shifts	70 per calendar year
Home Health Care Maximum Visits	120 per calendar year
Bariatric Surgery Lifetime Maximum	\$ 5,000
Spinal Disorder Maximum	20 visits per calendar year

Hearing Aid Maximum	
Children to age 19	1 per 24 months
Adults	1 per 36 months
Maximum Allowed**	\$1,000 per purchase

**Applies to Durable Medical and Surgical Equipment Maximum

Durable Medical and Surgical Equipment Maximum (includes hearing aids and prosthetics)	\$ 10,000 per calendar year
---	-----------------------------

National Medical Excellence	
Lodging Expenses Maximum	\$ 50 per person per night
Travel and Lodging Maximum	\$ 10,000 per episode of care

Private Room Limit	The institution's semiprivate rate.
--------------------	-------------------------------------

Lifetime Maximum Benefit: There is no Lifetime Maximum Benefit (overall limit) that applies to the Special Comprehensive Medical benefits described in the Booklet. The only maximum benefit limits are those specifically mentioned in your Booklet.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.
- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

The expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, no benefits will be paid.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

Your Health Benefits

This Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Your Physician

You may choose the services of either a **Preferred Care** or a **Non-Preferred Care Provider**. You may also self-refer to specialists. If you choose a **Primary Care Physician**, consult your **Primary Care Physician** whenever you have questions about your health. He or she provides basic and routine care, and can refer you to specialists and facilities in the network, when medically necessary.

Primary and Preventive Care

Your selected **Primary Care Physician** can provide preventive care and treat you for illnesses and injuries. Although you are not required to select a **Primary Care Physician**, you are encouraged to do so. It is to your financial benefit to use **Preferred Care Providers**. The plan pays a higher coinsurance payment percentage for their services and you are only subject to the **Primary Care Physician** copay when accessing care from your selected **Primary Care Physician**. In addition, **Preferred Care Providers** accept the negotiated rate for services rendered. Using the non-preferred provider services means that you will be responsible for charges in excess of the negotiated rate. Please note that care received from any other network physician is subject to the specialist copay.

Coverage for out-of-network primary and preventive care is limited. Refer to the "Summary of Coverage" for details.

Prescription Drug Expense Coverage

This section does not provide benefits covering expenses incurred for all **prescription drugs**. A **prescription drug** may not be covered unless it is necessary for the prevention or treatment of an illness or condition. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet.

The Summary of Coverage outlines the Coinsurance or Payment Percentages that apply to the Covered **Prescription Drug** Expenses described below.

Covered Prescription Drug Expenses

This Plan pays the benefits shown below for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by a **preferred pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **preferred pharmacy's** charge for the drug is more than the **copay** per **prescription** or refill.

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by a **preferred pharmacy** will be an amount equal to the Coinsurance or Payment Percentage of the total charges. The total charge is determined by:

- the **preferred pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf.

No benefit will be paid for a **prescription drug** dispensed by a **non-preferred pharmacy** under this benefit section except for an **emergency condition**, in which case the benefit will be payable at the preferred level of coverage.

Limitations

No benefits are paid under this section:

- For any **prescription drug** dispensed by a non-preferred **pharmacy**.
- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 30 day supply of any drug dispensed by a **mail order pharmacy**.
- For more than a 30 day supply per **prescription** or refill. However, this limitation does not apply to a supply of up to 90 days per **prescription** or refill for drugs which are provided by a **mail order pharmacy**.
- For the administration or injection of any drug.
- For the following injectable drugs:

fertility drugs;

Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year.

- For any refill of a drug that is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:

if the **prescriber** has not specified the number of refills; or

if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.

- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by your Employer.
- For any drugs which do not, by federal or state law, require a prescription order (i.e. an over-the-counter (OTC) drug), even if a prescription is written.
- Any **Prescription Drug** for which there is an over-the-counter (OTC) product which has the same active ingredient and strength.
- For biological sera and blood products.
- For nutritional supplements.
- For any fertility drugs.
- For any drug used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy:

sildenafil citrate;

phentolamine;

apomorphine;

alprostadil; or

any other **prescription drug** that

is in a similar or identical class,
has a similar or identical mode of action or exhibits similar or identical outcomes.

- For more than a 90-day supply per calendar year of any smoking cessation aids or drugs.
- For appetite suppressants.
- For a **prescription drug** dispensed by a **mail order pharmacy** that is not a **preferred pharmacy**.

Certification For Certain Prescription Drugs-Step Therapy Program

Under the Step Therapy Program:

- The use of one or more prerequisite therapy drugs is required prior to the time a Step Therapy drug is dispensed in order for a Step Therapy drug to be considered a Covered **Prescription Drug** Expense.
- No benefits will be payable for a Step Therapy drug unless:

the corresponding prerequisite therapy drug(s) are used first. However, if it is **Necessary** for you to be initially treated with a Step Therapy drug the **Prescriber** of the drug may request a medical exception by following the Certification Procedures section below.

- Refer to the Step Therapy List in the Medication Formulary Guide to determine which **Prescription Drugs** require the use of prerequisite therapy drugs. The Step Therapy List is subject to periodic review and modification by Aetna.

Certification Procedures

It is your responsibility to arrange for the **prescriber** of the drug to call the number shown on your ID Card to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug.

Written notice of the certification decision will be sent promptly to you. This notice will show:

- the approved period of certification, during which time any authorized refills of the drug may be dispensed; or
- when certification is denied, the procedure to follow if you choose to appeal the decision.

If the drug is to be dispensed after the certification period ends, certification must again be requested, as described above.

Certification For Certain Prescription Drugs

Certification of the necessity of certain **prescription drugs** is required before the drug is dispensed by a **preferred pharmacy**.

When one of the **prescription drugs** shown below is dispensed, expenses incurred will be payable as follows:

- If certification has been requested and the drug is **necessary**:

Benefits will be payable at the Payment Percentage.

- If certification has not been requested and the drug is **necessary**:

No benefits will be payable.

- If the drug is not **necessary**:

No benefits will be payable whether or not certification has been requested.

Certification Procedures

It is your responsibility to arrange for the **prescriber** of the drug to call the number shown on your ID Card to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug.

Written notice of the certification decision will be sent promptly to you. This notice will show:

- the approved period of certification, during which time any authorized refills of the drug may be dispensed; or
- when certification is denied, the procedure to follow if you choose to appeal the decision.

If the drug is to be dispensed after the certification period ends, certification must again be requested, as described above.

List of Prescription Drugs Requiring Certification

The following **prescription drugs** require certification before a drug is dispensed:

- Epoetin.
- Filgrastim.
- Growth hormones.
- Interferon alfa.
- Interferon beta.
- Leuprolide.

Check the Medication Formulary Guide for other drugs that require certification.

Special Comprehensive Medical Coverage

Although a specific service may be listed as a covered expense, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of an illness or condition. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

The Summary of Coverage outlines the Coinsurance or Payment Percentages that apply to the Covered Medical Expenses described below.

Covered Medical Expenses

Covered Medical Expenses are the charges incurred for certain facilities and other medical services and supplies that are covered in whole or in part by this Plan. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

Hospital Expenses

Inpatient Hospital Expenses

Charges made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

Not included is any charge for daily **board and room** in a private room over the **semiprivate rate**.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Outpatient Hospital Expenses

Charges made by a hospital for hospital services and supplies which are given to a person who is not confined as a full-time inpatient.

Emergency Care in an Emergency Room

These are charges made by a hospital for emergency care treatment received in the emergency room of a hospital while a person is not a full-time inpatient.

Outpatient Surgical Expenses

Covered Medical Expenses include charges for outpatient surgical expenses to the extent shown below.

Covered Medical Expenses include charges made:

- in its own behalf by:
 - a **surgery center**;
 - the outpatient department of a **hospital**; or
 - an office based surgical facility of a **physician** or a **dentist**.
- by a **physician**;
- on behalf of a salaried staff **physician** by the outpatient department of a **hospital**.

for Outpatient Services and Supplies furnished in connection with a surgical procedure performed in the center or in a hospital. The procedure must meet these tests:

- It is not expected to:
 - result in extensive blood loss;
 - require major or prolonged invasion of a body cavity; or
 - involve any major blood vessels.
- It can safely and adequately be performed only in a **surgical center** or in a **hospital** or in an office based surgical facility of a **physician** or a **dentist**.
- It is not normally performed in the office of a **physician** or a **dentist**.

Outpatient Services and Supplies

These are:

- Services and supplies furnished by the **surgery center** or by a **hospital** on the day of the procedure.
- Services of the operating **physician** for performing the procedure and for:
 - related pre and postoperative care; and
 - the administering of an anesthetic.
- Services of any other **physician** for related postoperative care and for the administering of an anesthetic. This does not include a local anesthetic.

Limitations:

No benefit is paid for charges incurred:

- For the services of a **physician** who renders technical assistance to the operating **physician**.
- While the person is confined as a full-time inpatient in a **hospital**.

Convalescent Facility Expenses

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the **semiprivate rate**.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physician's** services.
- Medical Supplies.

Benefits will be paid for no longer than the Convalescent Days Maximum during any one calendar year.

Limitations to Convalescent Facility Expenses

This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

Home Health Care Expenses

Home health care expenses are covered if:

- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by a **R.N.** or **L.P.N.** if a **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital or convalescent facility**:

medical supplies;

drugs and medicines prescribed by a **physician**; and

lab services provided by or for a **home health care agency**.

There is a maximum to the number of visits covered in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Health Care Expenses

This section does not cover charges made for:

- Services or supplies that are not a part of the **home health care plan**.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation.

Routine Physical Exam Expenses

The charges for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. If charges made by a **physician** in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included as a part of the exam are:

- X-rays, laboratory and other tests including a Pap Smear given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For your dependent child:

To qualify as a covered physical exam, the **physician's** exam must include at least:

- a review and written record of the patient's complete medical history;
- a check of all body systems; and
- a review and discussion of the exam results with the patient or with the parent or guardian.

For all exams given to your child under age 2, Covered Medical Expenses will not include charges for:

- More than 7 exams in the first year of the child's life.
- More than 2 exams in the second year of the child's life.

For all exams given to your child age 2 up to age 19, Covered Medical Expenses will not include charges for more than one exam in 12 months in a row.

For all exams given to your child age 19 and over, Covered Medical Expenses will not include charges for more than one exam in 24 months in a row.

For all exams given to you or your spouse, Covered Medical Expenses will not include charges for:

more than one exam in 24 months in a row for a person age 19 to age 65; or
more than one exam in 12 months in a row for a person age 65 and over;

Also included as Covered Medical Expenses are charges made by a **physician** for:

- immunizations, including travel immunizations;
- one annual routine gynecological exam. Included as part of the exam is a routine Pap smear, and for a female age 40 and over an annual routine mammogram;
- one annual routine prostate specific antigen test and digital rectal exam for a male age 40 and over;
- a routine sigmoidoscopy or colonoscopy and fecal occult blood stool test every 5 years beginning at age 50.

Not covered are charges for:

- services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer;
- services which are for diagnosis or treatment of a suspected or identified injury or disease;
- exams given while the person is confined in a **hospital** or other place for medical care;
- services not given by a **physician** or under his or her direction;
- medicines, drugs, appliances, equipment or supplies;
- psychiatric, psychological, personality or emotional testing or exams;
- exams in any way related to employment;
- premarital exams;
- vision or dental exams;
- a **physician's** office visit in connection with immunization or testing for tuberculosis.

Routine Hearing Exam Expenses

Covered Medical Expenses include charges for an audiometric exam. The services must be performed by:

a physician certified as an otolaryngologist or otologist; or
an audiologist who either:

is legally qualified in audiology; or

holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and

who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Covered Medical Expenses will not include charges for more than one hearing exam in 24 months in a row.

Not included are charges for:

- any ear or hearing exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- any hearing care service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a **hospital** or other facility for medical care;
- any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government, or

Skilled Nursing Care Expenses

The charges made by a **R.N.** or **L.P.N.** or a nursing agency for "skilled nursing services" are included as Covered Medical Expenses. No other charges made by a **R.N.** or **L.P.N.** or a nursing agency are covered. As used here, "skilled nursing services" means these services:

- Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by a **R. N.** or **L.P.N.** if the person's condition requires **skilled nursing care** and visiting nursing care is not adequate.

Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Not included as "skilled nursing services" is:

- that part or all of any nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs and companionship activities; or
- any private duty nursing care, given while the person is an inpatient in a **hospital** or other health care facility; or
- care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- care provided solely for skilled observation except as follows:

for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:

change in patient medication;

need for treatment of an **emergency condition** by a **physician**, or the onset of symptoms indicating the likely need for such services;

surgery; or

release from inpatient confinement; or

- any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

Hospice Care Expenses

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses

The charges made in its own behalf by a:

- **hospice facility;**
- **hospital;** or
- **convalescent facility;**

which are for:

Inpatient Care

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:

pain control; and

other acute and chronic symptom management.

- Not included is any charge for daily board and room in a private room over the Private Room Limit.

Outpatient Care

- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses For Outpatient Care

Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:

assessment of the person's:

social, emotional, and medical needs; and

the home and family situation;

identification of the community resources which are available to the person; and

assisting the person to obtain those resources needed to meet the person's assessed needs.

- Psychological and dietary counseling.
- Consultation or case management services by a **physician**.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.
- Respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Charges made by the providers below for Outpatient Care, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:

physical and occupational therapy;

part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;

medical supplies;

drugs and medicines prescribed by a **physician**; and

psychological and dietary counseling.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.

Contraception Expenses

Covered Medical Expenses include:

- charges incurred for contraceptive drugs and contraceptive devices that by law need a physician's prescription; and that have been approved by the FDA.
- related outpatient contraceptive services such as:
 - consultations;
 - exams;
 - procedures; and
 - other medical services and supplies.

Not covered are:

- charges for services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer; and
- charges incurred for contraceptive services while confined as an inpatient; or
- charges for contraceptive **prescription drugs**. (Refer to your **prescription drug** plan benefits.)

Infertility Services Expenses

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for diagnosis and treatment of the underlying cause of infertility if:

- There exists a condition that:

is a demonstrated cause of infertility; and

has been recognized by a gynecologist or infertility specialist; and

is not caused by voluntary sterilization or a hysterectomy;

or

For a female who is:

under age 35, she has not been able to conceive after one year or more without contraception; or

age 35 or older, she has not been able to conceive after six months without contraception.

Not covered are charges for:

- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Cryopreservation or storage of cryopreserved embryos.
- Gestational carrier programs.
- Home ovulation prediction kits.
- In vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection.
- Frozen embryo transfers, including thawing.
- Ovulation induction with ovulatory stimulant drugs.
- Artificial insemination.
- Infertility drugs.

Outpatient Short-Term Rehabilitation Expense Coverage

The charges made by:

- a **physician**; or
- a licensed or certified physical, occupational or speech therapist;

for the following services for treatment of acute conditions are Covered Medical Expenses.

Short-term rehabilitation is therapy which is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to:

- an injury;
- a disease; or
- congenital defect.

Short-term rehabilitation services consist of:

- neurodevelopmental therapy for children under the age of 6;
- massage/naturopathic therapy if there is a treatment plan;
- physical therapy;
- occupational therapy, or
- speech therapy,

furnished to a person who is not confined as an inpatient in a **hospital** or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Plan.
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an Employer.
- Services received while the person is confined in a **hospital** or other facility for medical care.
- Services not performed by a **physician** or under his or her direct supervision.
- Services rendered by a physical, occupational, or speech therapist who resides in the person's home or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from:

disease;

injury; or

congenital defect.

- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.

- Treatment for which a benefit is or would be provided under the Spinal Manipulation Expenses section, whether or not benefits for the maximum number of visits under that section have been paid.

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:

- details the treatment to be rendered and the frequency and duration of the treatment.
- provides for ongoing reviews and is renewed only if therapy is still necessary.

Spinal Manipulation Expenses

Covered Expenses

Covered Medical Expenses include charges for treatment of spinal subluxation or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Maximum Benefit

Not more than the Spinal Manipulation maximum visits will be payable in any one calendar year for all expenses in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating **physician**.

Neurodevelopmental Therapy Expenses

The charges made for the services of a **physician** for rendering Neurodevelopmental Therapy Services to dependent children under the age of 6 are included as Covered Medical Expenses.

Neurodevelopmental Therapy Services means speech therapy, physical therapy or occupational therapy given to:

restore or improve a speech or body function; or

develop a speech or body function delayed by a neurological disease; or

maintain a speech or body function if, without therapy, a neurological disease would cause significant deterioration in the person's condition.

Not included are charges for:

Any services unless they are prescribed by a **physician** in accordance with a specific treatment plan which details the treatment to be rendered and the frequency and duration of the treatment and provides for on-going reviews and is renewed only if therapy is still **necessary**.

Services rendered by a person who resides with you or who is part of your family.

Durable Medical Equipment

Expenses for durable medical and surgical equipment are Covered Medical Expenses to the extent shown below.

Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

Repair of purchased equipment.

Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Hearing Aids. Not more than the Hearing Aid Maximum shown in the Summary of Coverage will be payable.

Not included are charges for more than one item of equipment for the same or similar purpose.

Not more than the Durable Medical Equipment Calendar Year Maximum shown in the Summary of Coverage will be payable in any one calendar year.

Durable Medical and Surgical Equipment: This is equipment that is:

- Made to withstand prolonged use.
- Made for and mainly used in the treatment of a disease or injury.
- Suited for use in the home.
- Not normally of use to persons who do not have a disease or injury.
- Not for use in altering air quality or temperature.
- Not for exercise.

Other Medical Expenses

These include:

- Charges made by a **physician**.
- Charges for the following:

Diagnostic lab work and X-rays.

X-rays, radium, and radioactive isotope therapy.

Anesthetics and oxygen.

Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.

Artificial limbs and eyes. Not included are charges for:

eyeglasses;

vision aids;

communication aids; and

orthopedic shoes.

National Medical Excellence Program® (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that cannot be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

Travel Expenses

These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses

These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum

For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:

one year after the day the procedure is performed; and

the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Limitations

Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

Explanation of Some Important Plan Provisions

Inpatient Facility Admission Copay

This is the amount of Inpatient Facility Expenses you pay for each **hospital** or each **residential treatment facility** confinement of a person. Not more than 3 Inpatient Facility Admission Copays will apply to all confinements of a person in any one calendar year.

The Inpatient Facility Admission Copay will only be applied once to all **hospital** or **residential treatment facility** confinements, regardless of cause, which are separated by less than 10 days.

Expenses used to meet the Inpatient Facility Admission Copay cannot be used to meet any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Inpatient Facility Admission Copay.

Individual Calendar Year Deductible

This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

Family Calendar Year Deductible

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Individual Calendar Year Deductibles equal the Family Calendar Year Deductible, you and your dependents will be considered to have met the separate Individual Calendar Year Deductibles for the rest of that calendar year.

Hospital Emergency Room Copay

A separate Hospital Emergency Room Copay applies to each visit for **emergency care**, by a person to a **hospital's** emergency room, unless the person is admitted to the **hospital** as an inpatient immediately following a visit to a **hospital** emergency room.

Urgent Care Copay

A separate Urgent Care Copay applies to each visit for urgent care by a person to an **Urgent Care Provider** unless the person is admitted to the **hospital** as an inpatient immediately following a visit to an **Urgent Care Provider**.

Limitations

Prescription Drugs and Medicines

Covered Expenses do not include drugs or medicines:

- which are provided while a person is not confined as an inpatient in a health care facility; or
- for which a benefit is payable under any other part of this plan; or
- which are obtainable through the **prescription drug** program sponsored by your Employer.

Mouth, Jaws and Teeth

Covered Expenses

Covered Medical Expenses are only charges for services and supplies for the treatment of conditions of or related to the following:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, "**physician**" includes a **dentist**.

Hospital services and supplies received for an inpatient **hospital** confinement required because of the person's condition.

Surgery

This is surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment

This is non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

Dental Work, Surgery and Orthodontic Treatment

This is dental work, surgery and **orthodontic treatment** needed due to an injury to remove, repair, replace, restore or reposition:

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut.

Any such teeth must have been free from decay,; in good repair, firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the calendar year of the accident or the next one.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only 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.

Except as provided for injury, not included are charges:

- for crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for tooth removal.

Limitations

Covered Medical expenses do not include charges:

- to remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures, or bridgework;
- for periodontal treatment;
- for dental cleaning, in-mouth scaling, planing, or scraping;
- for myofunctional therapy; this is:

muscle training therapy; or

training to correct or control harmful habits.

Acupuncture Services

Covered Medical Expenses include those charges incurred for acupuncture services furnished to a covered family member only if provided by:

- A physician; or
- An acupuncturist certified by the American Association for Acupuncture and Oriental Medicine who is practicing within the laws of the jurisdiction where treatment is given.

Acupuncture services are those which are furnished:

- As a form of anesthesia in connection with surgery that is covered under this policy
- To treat a non-occupational disease or non-occupational injury.
- To alleviate chronic pain.

Benefits for acupuncture services will be paid at the Coinsurance or Payment Percentage.

Emergency Room Treatment

Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Coinsurance or Payment Percentage.

Non-Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

no benefits will be payable.

Treatment by an Urgent Care Provider

*You should not seek medical care or treatment from an **Urgent Care Provider** if your illness; injury; or condition; is an **emergency condition**. Please go directly to the emergency room of a **hospital** or call 911 (or the local equivalent) for ambulance and medical assistance.*

Urgent Care

This Plan pays for the charges made by an **Urgent Care Provider** to evaluate and treat an urgent condition.

When travel to an **Urgent Care Provider** for treatment of an urgent condition is not feasible, such treatment may be paid at the Preferred level of benefits. If a claim for treatment of an urgent condition is paid at the Non-Preferred level and you believe that it should have been paid at the Preferred level, please contact Members Services at the toll-free number on your I.D. card.

Non-Urgent Care

Covered medical expenses for charges made by an **Urgent Care Provider** to treat a non-urgent condition will be paid at the Coinsurance or Payment Percentage.

Non-urgent care includes, but is not limited to, the following:

- routine or preventive care (this includes immunizations);
- follow-up care;
- physical therapy;
- elective surgical procedures; and
- any lab and radiologic exams which are not related to the treatment of the urgent condition.

Bariatric Surgery Expenses

Covered Medical Expenses include charges made on an inpatient or outpatient basis by a **hospital** or a **physician** for the surgical treatment of **morbid obesity** of a covered person.

Coverage is included for one **morbid obesity** surgical procedure, including related outpatient services, within a two-year period, beginning with the date of the first **morbid obesity** surgical procedure, unless a multi-stage procedure is planned. Coverage is subject to the Bariatric Surgery Lifetime Maximum shown in the Summary of Coverage.

Not included are charges for any service or supply furnished by a **Non-Preferred Care Provider**.

Certification For Hospital Admissions

This certification section applies to admissions other than those for the treatment of alcoholism, drug abuse, or **mental disorders**. A separate section below applies to such admissions.

If:

- a person becomes confined in a **Non-Preferred Care hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by:

your **Primary Care Physician**; or

a **Preferred Care Provider**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:

If certification has been requested and denied:

No benefits will be paid for Hospital Expenses incurred for board and room.

Benefits for all other Hospital Expenses will be paid at the Coinsurance or Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

No benefits will be paid for Hospital Expenses incurred for board and room.

As to all other Hospital Expenses:

Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for such expenses in excess of the Excluded Amount will be paid at the Coinsurance or Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:

Hospital Expenses incurred for board and room, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Hospital Expenses will be payable at the Coinsurance or Payment Percentage.

- As to other Covered Medical Expenses:

Benefits will be paid at the Coinsurance or Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied to expenses for **hospital** room and board.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency admission** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician** or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

Certification for Convalescent Facility Admissions, Home Health Care, Hospice Care, and Skilled Nursing Care

If a person incurs Covered Medical Expenses:

- while confined in a **convalescent facility** or a **hospice facility**; or
- for a service or a supply for home health care or **hospice care** while not confined as an inpatient or **skilled nursing care**; and

it has not been certified that:

- such confinement or any day of it is **necessary**; or
- such other services or supplies (either specifically or as a part of a planned program of care) are **necessary**, and
- the confinement or service or supply has not been ordered or prescribed by:

your **Primary Care Physician**; or

a **Preferred Care Provider;**

such Covered Medical expenses will be paid only as follows:

- As to Convalescent Facility Expenses and **Hospice Care** Facility Expenses incurred while confined in a **convalescent facility** or a **hospice facility**:

If certification has been requested and denied:

No benefits will be paid for Convalescent Facility Expenses or **Hospice Care** Facility Expenses incurred for board and room.

Benefits for all other Convalescent Facility Expenses or **Hospice Care** Facility Expenses incurred during the confinement will be paid at the Coinsurance or Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

No benefits will be paid for Convalescent Facility Expenses or **Hospice Care** Facility Expenses incurred for board and room.

As to all other Convalescent Facility Expenses or **Hospice Care** Facility Expenses incurred during the confinement:

Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other such expenses will be paid at the Coinsurance or Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:

Convalescent Facility Expenses or **Hospice Care** Facility Expenses, incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other such expenses, incurred during the confinement, will be paid at the Coinsurance or Payment Percentage.

As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Coinsurance or Payment Percentage.

- As to Covered Medical Expenses incurred for services or supplies either as stated or as a part of a planned program of care for home health care, **hospice care** while not confined as an inpatient, or **skilled nursing care**:

If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not **necessary**, no benefits will be paid for the denied or unnecessary service or supply.

If certification has not been requested for a service or supply and the service or supply is **necessary**, benefits for the **necessary** service or supply will be paid as follows:

Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Coinsurance or Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan; except that:

- To the extent that a day of confinement has been certified, the exclusion of services and supplies because they are not **necessary** will not apply to:

Convalescent Facility Expenses for room and board; or

Hospice Care Facility Expenses for room and board.

- To the extent that such service or supply has been certified for home health care, **hospice care**, or **skilled nursing care**, the exclusion of services or supplies because they are not **necessary** will not apply to such service or supply.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies.

Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If:

- services and supplies for **hospice care** provided to a person have been certified; and
- the person later requires confinement in a **hospital** for pain control or acute symptom management;

any other certification requirement in this Plan will be waived for any such day of confinement in a **hospital**.

Certification For Hospital and Residential Treatment Facility Admissions for Alcoholism, Drug Abuse, or Mental Disorders

If, in connection with the treatment of alcoholism, drug abuse, or a **mental disorder**, a person incurs Covered Medical Expenses while confined in a **hospital** or **residential treatment facility**; and

- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by the Aetna Managed Behavioral Healthcare Coordinator, your **Primary Care Physician**, or a **Preferred Care Provider**:

Covered Medical Expenses incurred on any day not certified during the confinement will be paid only as follows:

With respect to expenses for **hospital** and **residential treatment facility** board and room:

If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not **necessary**, no benefits will be paid.

If certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

With respect to all other **hospital** and **residential treatment facility** expenses:

If certification has been requested and denied, or if certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

If certification has not been requested and the confinement is not **necessary**, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not **necessary** will not be applied to **hospital** and **residential treatment facility** board and room.

To get the days certified, you must call the Aetna Managed Behavioral Healthcare Coordinator at the number shown on your ID card. Such certification must be obtained before confinement as a full-time inpatient, or in the case of an **emergency admission**, within 48 hours after the start of a confinement as a full-time inpatient or as soon as reasonably possible.

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

Treatment of Alcoholism, Drug Abuse, or Mental Disorders

Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment

If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **residential treatment facility**;

then the coverage is as shown below.

Hospital

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Effective treatment of alcoholism or drug abuse.**
- Treatment of **mental disorders**.

Residential Treatment Facility

Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a private room over the semiprivate rate.
- Other **necessary** services and supplies.

Calendar Year Maximum Benefit

A Special Inpatient Calendar Year Maximum Days applies to the **hospital** and **residential treatment facility** expenses described above. See your Summary of Coverage for details.

Outpatient Treatment

If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **residential treatment facility**;

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital, residential treatment facility** or **physician**, benefits will not be payable for more than the Special Outpatient Calendar Year Maximum Visits in any one calendar year. See your Summary of Coverage for details.

General Exclusions

General Exclusions Applicable to Your Health Benefits

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician or dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician or dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

there is insufficient 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

if required by the 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, investigational, or for research purposes; or

the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

the disease can be expected to cause death within one year, in the absence of effective treatment; and

the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays except as provided for in the section of the booklet entitled "Neurodevelopmental Therapy Expenses."
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.

- Those for services and supplies:

Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:

sildenafil citrate;
 phentolamine;
 apomorphine;
 alprostadil; or
 any other drug that

is in a similar or identical class,
 has a similar or identical mode of action or exhibits similar or identical outcomes.

This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.

- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in your Booklet.
- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those for services and supplies that, in the opinion of the Claims Administrator or its authorized representative, are associated with injuries, illness, or conditions suffered due to the acts or omissions of a third party.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

Improve the function of a part of the body that:

is not a tooth or structure that supports the teeth; and

is malformed:

as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or

as a direct result of:

disease; or

surgery performed to treat a disease or injury.

Repair an injury. Surgery must be performed:

in the calendar year of the accident which causes the injury; or

in the next calendar year.

- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for the reversal of a sterilization procedure.
- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans

Coordination of Benefits - Other Plans Not Including Medicare

Benefits Subject To This Provision: This Coordination of Benefits (COB) provision applies to This Plan when an employee or the employee's covered dependent has medical and/or dental coverage under more than one Plan. "Plan" and "This Plan" are defined herein.

The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total **allowable expense**.

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

Allowable Expense means a health care service or expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a **semi-private** room in the **hospital** and the private room (unless the patient's stay in the private **hospital** room is medically necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage of **hospital** private rooms) is not an allowable expense.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense, unless the secondary plan's provider's contract prohibits any billing in excess of the provider's agreed upon rates.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary Plan's payment arrangements shall be the allowable expense for all the Plans.
5. The amount a benefit is reduced by the primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Claim Determination Period means the Calendar Year.

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

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

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

- A. Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- B. Other prepaid coverage under service plan contracts, or under group or individual practice;
- C. Uninsured arrangements of group or group-type coverage;
- D. Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
- E. Medicare or other governmental benefits;
- F. Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

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

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Order Of Benefit Determination.

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

- A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- B. A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- D. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:
 - (1) **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:

(a) The primary plan is the plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

(b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

(c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

(3) **Active or Inactive Employee.** The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule labeled D(1).

(4) **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, subscriber longer is primary.

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

Effect On Benefits Of This Plan.

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

- (1) Determine its obligation to pay or provide benefits under its contract;
- (2) Determine whether a benefit reserve has been recorded for the covered person; and
- (3) Determine whether there are any unpaid allowable expenses during that claims determination period.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans. There is no duplicate or multiple coverage under this plan.

Right To Receive And Release Needed Information.

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

Facility Of Payment.

Any payment made under another Plan may include an amount which should have been paid under This Plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Aetna will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery.

If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Effect of Medicare

The following provisions explain how the benefits under This Plan interact with benefits available under Medicare.

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

A person is "eligible for Medicare" if he or she:

- is covered under it by reason of age, disability, or End Stage Renal Disease;
- is not covered under it because of:

having refused it;

having dropped it; or

having failed to make proper request for it.

If a person is eligible for Medicare, this Plan will pay for such benefits as for such person as the Primary Payor or Secondary Payor, as follows:

If your coverage for this Plan's benefits is based on current employment with the Employer, this Plan will act as the Primary Payor for the Medicare beneficiary who is eligible for Medicare:

- (a) solely due to age if this Plan is subject to the Social Security Act requirements for Medicare with respect to working aged (i.e., generally a plan of an employer with 20 or more employees).
- (b) due to end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits. But this does not apply if at the start of such eligibility the person was already eligible for Medicare benefits and this Plan's benefits were payable on a Secondary basis.
- (c) solely due to any disability other than end stage renal disease; but only if this plan meets the definition of a large group health plan in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

Otherwise, This Plan will cover the benefits as the Secondary Payor. This Plan will pay the difference between the benefits of this Plan and the benefits that Medicare pays, up to 100% of "Plan Expenses." "Plan Expenses" means any **necessary** and reasonable health expenses, part or all of which is covered under this Plan.

Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules.

Exclusions

Those charges for non-emergency care or treatment furnished by a covered person's physician under a Private Contract are excluded. A Private Contract is a contract between a Medicare beneficiary and a **physician** who has decided not to provide services through Medicare.

This exclusion applies to services an "opt out" physician has agreed to perform under a Private Contract signed by the covered person. Physicians who have decided not to provide services through Medicare must file an "opt out" affidavit with all carriers who have jurisdiction over claims the physician would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into with a Medicare beneficiary.

Right to Receive and Release Needed Information.

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

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next service fee due date following the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 30 months from the start of the absence. Refer to your Employer for details on disability coverage.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer. Refer to your Employer for details relating to coverage during a lay-off or leave of absence.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under this Plan.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

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

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

Handicapped Dependent Children

Health Benefits Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued a personal medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age.

Continuation of Coverage For Your Dependents After Your Death

If you die while covered under any part of this Plan, any Health Expense Coverage then in force for your dependents will be continued. But your Employer must continue to make required payments.

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

- The end of the calendar month after the calendar month of your death.
- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for like coverage under this Plan.
- Dependent coverage ceases as to the Eligible Class of which you were a member right before your death.
- Any required contributions cease.

If Health Expense Coverage is being continued for your dependents, your child born after your death will also be covered.

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

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

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Additional Provisions

The following additional provisions apply to your coverage:

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the Plan Document on file with your Employer. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued as to all or any class of employees.

Assignments

Coverage may be assigned only with the written consent of Aetna.

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 constitutes 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 the 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, including from any Insurance Coverage, 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 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.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

Reporting of Claims

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

All claims should be reported promptly. The deadline for filing a claim for any benefits is 15 months after the date of the loss causing the claim.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received.

All benefits are payable to you. However, this Plan has the right to pay any health benefits to the service provider.

This Plan may pay up to \$ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

Names of **physicians, dentists** and others who furnish services.

Dates expenses are incurred.

Copies of all bills and receipts.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Behavioral Health Provider

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

Board and Room Charges

Charges made by an institution for board and room and other **necessary** services and supplies. They must be regularly made at a daily or weekly rate.

Body Mass Index:

This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand Name Drug

A **prescription drug** which is protected by trademark registration.

Companion

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and

physical restoration services to help patients to meet a goal of self-care in daily living activities.

- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Copay

This is a fee, charged to a person, which represents a portion of the applicable expense. It is specified in the Summary of Coverage.

As to a **prescription drug** dispensed by a **preferred pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is dispensed. For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed. In no event will the copay be greater than the **prescription**, kit, or refill.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory

This is a listing of **Preferred Care Providers** in the **Service Area** covered under this Plan, which is given to your Employer for distribution to all employees covered under this Plan. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at www.aetna.com.

Durable Medical and Surgical Equipment

This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Effective Treatment of Alcoholism Or Drug Abuse

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Emergency Admission

One where the **physician** admits the person to the **hospital** or **residential treatment facility** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:

placing the person's health in serious jeopardy; or
serious impairment to bodily function; or
serious dysfunction of a body part or organ; or

in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care

This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Condition

This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Generic Drug

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home Health Care Agency

This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or a **R.N.**; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan

This is a plan that provides for care and treatment of a disease or injury.

The care and treatment must be:

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital, skilled nursing facility, or convalescent facility.**

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

Hospice Care Agency

This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:

skilled nursing services; and

medical social services; and

psychological and dietary counseling.

- Provides or arranges for other services which will include:

services of a **physician**; and

physical and occupational therapy; and

part-time home health aide services which mainly consist of caring for **terminally ill** persons; and

inpatient care in a facility when needed for pain control and acute and chronic symptom management.

- Has personnel which include at least:

one **physician**; and

one **R.N.**; and

one licensed or certified social worker employed by the Agency.

- Establishes policies governing the provision of **Hospice Care**.
- Assesses the patient's medical and social needs.
- Develops a **Hospice Care Program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **Hospice Care**, which:

- Is established by and reviewed from time to time by:

a **physician** attending the person; and

appropriate personnel of a **Hospice Care Agency**.

- Is designed to provide:

palliative and supportive care to **terminally ill** persons; and

supportive care to their families.

- Includes:

an assessment of the person's medical and social needs; and

a description of the care to be given to meet those needs.

Hospice Facility

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.

- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**; at least one such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a **R.N.**
- Has a full-time administrator.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

Jaw Joint Disorder

This is:

- a Temporomandibular Joint (TMJ) Dysfunction or any similar disorder of the jaw joint; or
- a Myofacial Pain Dysfunction (MPD); or
- any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.

This means a licensed practical nurse.

Late Enrollee

This is an employee in an Eligible Class who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the employee did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time.

However, an eligible employee or dependent may not be considered a Late Enrollee under certain circumstances. See the Special Enrollment Periods section of the Summary of Coverage.

Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail.

Medication Formulary

A listing of **prescription drugs** which have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both **brand name drugs** and **generic drugs** and is subject to periodic review and modification by Aetna. See your Employer for a current listing.

Mental Disorder

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

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

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

Morbid Obesity:

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

NME Patient

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, 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, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person 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, both as to the disease or injury involved and the person's overall health condition; 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 alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

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

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge

This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or

- result in any way from a disease that does.

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

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury

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

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

Non-Preferred Care

This is a health care service or supply furnished by a health care provider that is not **Preferred Care**.

Non-Preferred Care Provider

A health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**.

Non-Preferred Pharmacy

A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

Non-Specialist

A **physician** who is not a **specialist**.

Non-urgent Admission

One which is not an **emergency admission** or an **urgent admission**.

Orthodontic Treatment

This is any:

- medical service or supply; or
- dental service or supply;

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

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

whether or not for the purpose of relieving pain.

Not included is:

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

Pharmacy

An establishment where **prescription drugs** are legally dispensed.

Physician

This means a legally qualified physician.

Preferred Care

This is a health care service or supply furnished by:

- A person's **Primary Care Physician** or any other **Preferred Care Provider**.

- A **Non-Preferred Care Provider** on the referral of the person's **Primary Care Physician** and if approved by Aetna.
- Any health care provider for an **emergency condition** when travel to a **Preferred Care Provider** or referral by a person's **Primary Care Physician** prior to treatment is not feasible and
- A Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible.

Preferred Care is also care which is recommended and approved by the Aetna Managed Behavioral Healthcare Coordinator.

Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a **Preferred Care Provider** for:

- the service or supply involved; and
- the class of employees of which you are member.

Preferred Pharmacy

A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

Prescriber

Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription

An order of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

Prescription Drugs

Any of the following:

- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

Primary Care Physician

This is the **Preferred Care Provider** who is:

- selected by a person from the list of **Primary Care Physicians** in the **Directory**;
- responsible for the person's on-going health care; and
- shown on Aetna's records as the person's **Primary Care Physician**.

R.N.

This means a registered nurse.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the reasonable charge is the rate established in such agreement.

Residential Treatment Facility (Alcoholism Or Drug Abuse)

This is an institution that meets all of the following requirements:

- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7 days a week, which must be actively supervised by an attending **Physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **Physician** with evidence of close and frequent observation.
- On-site, licensed **Behavioral Health Provider**, medical or substance abuse professionals 24 hours per day/7 days a week.

Residential Treatment Facility (Mental Disorder)

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.

- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Semiprivate Rate

This is the **charge for board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area, as determined by Aetna in which **Preferred Care Providers** for this Plan are located.

Skilled Nursing Care

This means the following:

- Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours per day for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by a **R.N.** or **L.P.N.** if the person's condition requires **skilled nursing care** and visiting nursing care is not adequate. Private duty nursing care means care of not more than 8 hours per day for the purpose of performing specific skilled nursing tasks.

Skilled Nursing Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and

physical restoration services to help patients to meet a goal of self-care in daily living activities.

- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Specialist

A **physician** who:

practices in any generally accepted medical or surgical sub-specialty; and
is providing other than routine medical care.

A **physician** who:

practices in such a sub-specialty; and
is providing routine medical care (such as could be given by a **Primary Care Physician**),

will not be considered a Specialist for purposes of applying this plan's **copay** provisions.

Surgery Center

This is a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:

physicians who practice surgery in an area hospital; and

dentists who perform oral surgery.

- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a **R.N.**
- Is equipped and has trained staff to handle medical emergencies.
- It must have:

a **physician** trained in cardiopulmonary resuscitation; and

a defibrillator; and

a tracheotomy set; and

a blood volume expander.

- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

Terminally Ill

This is a medical prognosis of 6 months or less to live.

Urgent Admission

One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

This is:

- A freestanding medical facility which:

Provides unscheduled medical services to treat an urgent condition if the person's **physician** is not reasonably available.

Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.

Makes charges.

Is licensed and certified as required by any state or federal law or regulation.

Keeps a medical record on each patient.

Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.

Is run by a staff of **physicians**. At least one **physician** must be on call at all times.

Has a full-time administrator who is a licensed **physician**.

- A **physician's** office, but only one that:

has contracted with Aetna to provide urgent care; and
is, with Aetna's consent, included in the **Directory** as a Preferred Urgent Care Provider.

It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

This means a sudden illness; injury; or condition; that:

- is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health;
- includes a condition which would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment;
- does not require the level of care provided in the emergency room of a **hospital**; and
- requires immediate outpatient medical care that cannot be postponed until the covered person's **physician** becomes reasonably available.

Additional Information Provided by The McClatchy Company

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet. Your Plan Administrator has determined that this information together with the information contained in your booklet is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Employer Identification Number:

52-2080478

Plan Number:

501

Type of Plan:

Comprehensive Welfare Benefit and Cafeteria Plan

Type of Administration:

Administrative Services Contract with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

The McClatchy Company
2100 Q Street
Sacramento, CA 95816-6899
(916) 321-1961

Agent for Service of Legal Process:

Corporate Secretary
The McClatchy Company
2100 Q Street
Sacramento, CA 95816-6899

End of Plan Year:

December 31

Source of Contributions:

Employer and Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the Board of Directors.

Claim Procedures

Your booklet contains information on reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

Note: If applicable state law requires the Plan to take action on a claim or appeal in a shorter timeframe, the shorter period will apply.

Filing Health Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

"A claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Filing an Appeal of an Adverse Benefit Determination

Health Claims – Standard Appeals

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision, you may file a second level appeal within 60 days of receipt of the level one appeal decision. The appeal will be handled in the same timeframes as the first level appeal and a notice will be sent to you explaining the decision.

Exhaustion of Process

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

Health Claims – Voluntary Appeals

You may file a voluntary appeal of any final standard appeal determination. The voluntary appeal should be made for external review if the appeal qualifies, or to MCMC if the appeal does not qualify for external review. MCMC is an independent, third-party medical review organization, which has been contracted by the Company to conduct voluntary appeal reviews and deliver final, binding benefit determinations.

In addition, you may file a voluntary appeal to MCMC if you are dissatisfied with the determination made by external review. The "Appeal for External Review" section below provides more information regarding the external review appeal process.

You must complete all of the levels of standard appeal described above before you can appeal for external review or to MCMC. 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 under the standard appeal processes, described above.

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.

Appeal for External Review

Aetna's external review process gives members the opportunity to have certain coverage denials reviewed by independent physician reviewers. An appeal will be eligible for external review if the following are satisfied:

- the standard levels of appeal have been exhausted,
- the appeal is made by the member or the member's authorized representative,
- the coverage denial is based on Aetna's determination that the proposed or rendered service or supply is not medically necessary or is experimental or investigational, and
- the cost of the service or supply at issue for which the member is financially responsible exceeds \$ 500.

If upon the final standard level of appeal Aetna upholds the coverage denial and it is determined that the member is eligible for external review, the member will be informed in writing of the steps necessary to request an external review.

An independent review organization (IRO) refers the case for review by a neutral, independent physician with appropriate expertise in the area in question. Once all necessary information is submitted, the external review requests will generally be decided within 30 days of the request. Expedited reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. The decision of the independent external expert reviewer is binding on Aetna, the Company and the Health Plan. Members will not be charged a professional fee for the review.

Appeal to MCMC

If you choose to appeal to MCMC following an adverse determination by External Review where applicable or an adverse determination at the final level of standard appeals, you must do so in writing, and you should send the following information:

- The specific reason(s) for the appeal;
- Copies of all past correspondence with your Health Plan (including any EOBs); and
- Any applicable information that you have not yet sent to your Health Plan.

If you file a voluntary appeal, you will be deemed to authorize MCMC to obtain information from your Health Plan relevant to your claim.

Mail your written appeal directly to:

ERISA Appeals Unit
MCMC LLC
88 Black Falcon Avenue, Suite 353
Boston, MA 02210

MCMC will review your appeal. The MCMC reviewer will evaluate your claim within 60 days after you file your appeal and make a decision. If the reviewer needs more time, the reviewer may take an additional 60-day period. The reviewer will notify you in advance of this extension. The MCMC reviewer will follow relevant internal rules maintained by the applicable Health Plan to the extent they do not conflict with its own internal guidelines.

The MCMC reviewer will notify you of the final decision on your appeal electronically or in writing. The written notice will give you the reason for the decision and what Plan provisions apply.

All decisions by MCMC with respect to your claim shall be final and binding.

Additional Information

Retrospective Record Review

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of healthcare services. Aetna's effort to manage the services provided to members includes the

retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Concurrent Review and Discharge Planning

The following items apply if the Plan requires certification of any confinement, services, supplies, procedures, or treatments:

Concurrent Review

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.

Discharge Planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

Provider Networks

If plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers from The McClatchy Company, or by calling the toll-free Member Services number on your ID Card. A current list of providers in the Aetna network is available through DocFind®, at www.aetna.com.

ERISA Rights

As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice regarding Women's Health and Cancer Rights Act

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

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

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

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

If your employer offers Retiree coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to qualify for this extension you must provide a copy of your Disability Award letter that is received from the Social Security Administration prior to the end of your COBRA continuation period to the Plan administrator.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

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

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

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

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

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

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

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

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

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave.

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