Notice to Employees of

Sarah Lawrence College
(the "Customer")

Interpreter and Translation Services

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

French

Services d'interprétation et de traduction

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

Greek

Υπηρεσιες Μεταφρασεως

Για να λαβετε πληροφοριες οσον αφορα των υπηρεσιων μας μεταφρασεως σχετικα με την διαδικασια διοικητικη, μπορειτε να ερχοσαστε σε επαφη με την Υπηρεσια για τα Μελη στον αριθμο (χρωις διοδια) που βρισκεται επανω στην εξακριβωση σας ταυτοτητας. Οι επαγγελματικοι υπαλληλοι (του τμηματος της Αετνα το οποιο ανασχολειται με τους πελατες) μπορουν να χρησιμοποιουν την μεταφραστικη υπηρεσια της εταιρειας AT&T.

Italian

Servizi di traduzione e di interpretariato

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

Portuguese

Serviços de Intérprete e de Tradução

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

Russian

Услуги по устному и письменному переводу

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

Spanish

Servicio de Intérprete y Traducción

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

Haitian-Creole

Sèvis intèprèt ak tradiktè

Ou kapab pran kontak avèk Sèvis pou manm-yo si ou rele nimewo telefòn gratis ki sou kat I.D.-ou-a (idantifikasyon) pou ou jwenn ransèyman sou sèvis intèprèt ak tradiktè konsènan pwosedi administratif. Pwofesyonnèl nan sèvis kliyan "Aetna" gen mwayden jwenn sèvis tradiksyon nan "AT&T language line" (sèvis lang AT&T). Yon nimewo TDD disponnib tou pou moun ki pa tande byen.

Lao

ການບໍລິການນາຍພາສາແລະການແປພາສາ

ທ່ານສາມາດຕິດຕໍ່ພະແນກບໍລິການສະມາຊິກໄດ້ ໂດຍໃຊ້ເບີ�โทບໍລິການຟຣີທີ່ປາກົດເທິງບັດປະຈຳໂຮງສະມາຊິກຂອງທ່ານ ເພື່ອໄດ້ຮັບລາຍละເอียดຕ່າງໆ ກ່ຽວກັບການບໍລິການນາຍພາສາແລະບໍລິການແປພາສາທີ່ກ່ຽວຂ້ອງກັບການດຳເນີນການທາງດ້ານການບໍລິຫານ. ພະນັກງານຂອງພະແນກບໍລິການລູກຄ້າຂອງບໍລິສັດແອັດນາ (Aetna) ສາມາດຕິດຕໍ່ກັບການບໍລິການທາງດ້ານການແປພາສາໄດ້ ໂດຍຜ່ານສາຍແປພາສາ (Language Line) ຂອງບໍລິສັດ AT&T. ຍັງມີເບີ�โทຂອງละບົບ TDD ໄວ້ສຳຫລັບຜູ້ທີ່ໄດ້ຍິນສຽງບໍ່ຄັກໃຊ້ໃນການຕິດຕໍ່ອີກດ້ວຍ.

Cambodian

សេវាកម្មផ្លែកបកប្រែភាសា

អ្នកអាចទាក់ទងសេវាកម្មសមាជិក តាមរយៈលេខ ឥតគិតថ្លៃ ដែលចុះនៅលើកាតសំគាល់របស់អ្នក ដើម្បីទទួលពត៌មាន អំពី សេវាកម្មផ្លែកបកប្រែភាសា ដែលទាក់ទងនឹងវិធីចាត់ចែងការ ។ អ្នកជំនាញការផ្លែកសេវាកម្មនៃអតិថិជនរបស់ Aetna មានមធ្យោបាយរកសេវាកម្មបកប្រែតាមរយៈខ្សែទូរស័ព្ទភាសា AT&T ។ លេខ TDD# សំរាប់មនុស្សគថ្លង់ ក៏មានផងដែរ ។

Chinese

口譯及筆譯服務

您可以通過撥打列在您會員卡上的免費電話號碼與會員服務處聯絡，以便獲取有關實施程序的口譯及筆譯服務的資訊。Aetna的專業用戶服務人員使用AT&T語言專線 (AT&T Language Line) 的翻譯服務。還有一個專門為聽力有障礙的用戶提供的TDD號碼。

Arabic

خدمات الترجمة الشفهية والكتابية

تستطيع الاتصال بدائرة خدمات الأعضاء على رقم الهاتف المجاني المدرج على بطاقة هويتا للحصول على معلومات حول خدمات الترجمة الشفهية والكتابية المتعلقة بالإجراءات الإدارية فموظفو دائرة خدمة الزبائن لدى شركة Aetna يستطيعون تلقي خدمات الترجمة عن طريق خط اللغات لشركة AT&T. ويتوفر للأصماء أيضاً رقم جهاز إتصالات الأصماء (TDD).

BENEFIT PLAN

Extraterritorial Riders

Prepared Exclusively for
Sarah Lawrence College

Medical ET Rider

Aetna Life Insurance Company

These Extraterritorial Riders are part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

We want you to know℠

Aetna®

Table of Contents

ET Riders ..... Included in this document
California Medical 1
Connecticut Medical 5
Florida Medical 10
New Hampshire Medical 16
New Jersey Medical 29
Oregon Medical 30
Pennsylvania Medical 35

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Sarah Lawrence College
Group Policy No.:	GP-875727
Rider:	California ET Medical
Issue Date:	January 11, 2011
Effective Date:	November 1, 2010

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

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

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

(GR-9N 08-020 01 CA)

YOUR BOOKLET-CERTIFICATE CONTAINS IMPORTANT INFORMATION REGARDING NETWORK AND OUT-OF-NETWORK HEALTH CARE. PLEASE READ THIS INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

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

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

- 1 annual cervical cancer screening test, including the conventional Pap test, and any cervical cancer screening test approved by the federal Food and Drug Administration upon referral of the insured's health care provider.

Osteoporosis Services *(GR-9N 11-005 01 CA)*

Covered expenses include charges for services related to the diagnosis, treatment, and appropriate management of osteoporosis. The services include all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

Important Reminder

Refer to the Summary of Benefits for details about deductibles, coinsurance, benefit maximums and frequency limits if applicable.

Treatment of Infertility *(GR-9N 11-135-01 CA)*

Comprehensive Infertility Expenses

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

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

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

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

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

- Ovulation induction with menotropins is subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of this *Booklet-Certificate* and has a maximum of 6 cycles per lifetime; (in figuring the lifetime maximum, **Aetna** will take into consideration services received while you are covered under a group health plan as defined under the federal law known as ERISA that is offered by your employer through **Aetna** or one of its affiliated companies, or any other insured medical coverage); and
- Intrauterine insemination is subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of this *Booklet-Certificate* and has a maximum of 6 cycles per lifetime; (in figuring the lifetime maximum, **Aetna** will take into consideration services received while you are covered under a group health plan as defined under the federal law known as ERISA that is offered by your employer through **Aetna** or one of its affiliated companies, or any other insured medical coverage).

Exclusions and Limitations

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

- ART services for a female attempting to become pregnant who has *not* had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the **infertility** program;
- ART services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of sterilization surgery;
- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits;
- Injectable **infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
- Any services or supplies provided without pre-authorization from Aetna's infertility case management unit;
- **Infertility** Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not **infertile**;
- Any ART procedure or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); or
- Any charges associated with care required to obtain ART services (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); and any charges associated with obtaining sperm for any ART procedures.

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

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

Coverage for **Lifestyle/Performance drugs** is limited to the supply limits as described below.

Lifestyle/Performance Drugs
The following lifestyle/performance drugs:

- Sildenafil Citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Expenses include any prescription drug in oral or topical from that is similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.
- Coverage is limited to 4 pills or other form, determined cumulatively among all forms, for unit amounts as determined by **Aetna** to be similar in cost to oral forms, per 30 day supply. Mail order and 60 to 90 day supplies are not covered.

Continuation of Coverage Under California Law After COBRA Coverage is Exhausted *(GR-9N 31-025 01 CA)*

In accordance with California law, if you continued Health Expense Coverage under this Plan in accordance with federal law (PL 99-272-COBRA) for the maximum period for which such continuation is available to you, and if such maximum period is less than 36 months, you may, prior to the date coverage continuation under COBRA terminates, elect to further continue the same Health Expense Coverage for up to 36 months from the date your COBRA continuation of coverage began.

The election must include an agreement to pay premiums. The premiums may be up to 110% of the cost of the Plan (up to 150% if you are disabled pursuant to Title II or Title XVI of the Social Security Act). Premium payments must be continued.

You must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date **Aetna** informs you of any rights under this section. Within 45 days of such election, you must send to **Aetna** the amount required by **Aetna** as the first premium payment.

Coverage will terminate on whichever of the following is the earliest to occur:

- 36 months after your COBRA continuation period began. However, if you have been determined to have been disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of continuation coverage, you must provide notice to your Employer within 60 days of such determination and prior to the end of the 36 month continuation period. Coverage may only be continued if you are determined to be disabled.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage will be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that you are covered under another group health plan. However, continued coverage will not terminate under such time that you are no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The date you become entitled to benefits under Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.
- The month that begins more than 31 days after the date of the final determination under Title II or Title XVI of the Social Security Act that you are no longer disabled.

The Conversion Privilege will be available when coverage is no longer available under this section.

Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)

Additional Information Provided by Aetna Life Insurance Company

Inquiry Procedure

The plan of benefits described in the Booklet-Certificate is underwritten by:

Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156

Telephone: (860) 273-0123

If you have questions about benefits or coverage under this plan, call Member Services at the number shown on your Identification Card. You may also call Aetna at the number shown above.

If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the Consumer Service Division of the Department of Insurance at:

300 South Spring Street
Los Angeles, CA 90013

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

Participating Providers

We want you to know more about the relationship between Aetna Life Insurance Company and its affiliates (Aetna) and the participating, independent providers in our network. Participating physicians are independent doctors who practice at their own offices and are neither employees nor agents of Aetna. Similarly, participating hospitals are neither owned nor controlled by Aetna. Likewise, other participating health care providers are neither employees nor agents of Aetna.

Participating Providers are paid on a 'Discounted Fee For Service' arrangement. Discounted fee for service means that participating providers are paid a predetermined amount for each service they provide. Both the participating provider and Aetna agree on this amount each year. This amount may be different than the amount the participating provider usually receives from other payers.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Sarah Lawrence College
Group Policy No.:	GP-875727
Rider:	Connecticut ET Medical
Issue Date:	January 11, 2011
Effective Date:	November 1, 2010

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

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

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

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

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

Covered expenses include charges for pregnancy and childbirth expenses at the same level of any other applicable illness or injury. For inpatient care of the mother and newborn child, the plan will pay for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.

Any decision to shorten such minimum coverages shall be made by the attending physician; in consultation with the mother. In such cases; covered services shall include: home visits; parent education; and assistance and training in breast or bottle-feeding.

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

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

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

Precertification

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

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

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from **Aetna** for any services or supplies on the **precertification** list below. If you do not **precertify**, your benefits will be reduced by $500 or 50% of the cost of the expense whichever is less, or the plan may not pay any of the expenses if the service or supply is not medically necessary. The list of services requiring **precertification** follows on the next page.

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

The Precertification Process

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

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

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

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

For outpatient non-emergency medical services requiring **precertification**:	You or your **physician** must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.
For prenatal care and delivery:	As soon as possible after the attending **physician** confirms pregnancy and again within 48 hours of the birth or as soon thereafter as possible. No benefit reduction will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.

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

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

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

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

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

You are responsible for obtaining the necessary **precertification** from **Aetna** prior to receiving services from an **out-of-network provider**. Your provider may **precertify** your treatment for you; however you should verify with **Aetna** prior to the procedure, that the provider has obtained **precertification** from **Aetna**. If your treatment is not **precertified** by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered. If your treatment is not **precertified** by you or your **provider**, the benefit payable will be reduced by $500 or 50% of the expense whichever is less, or your expenses may not be covered if the service or supply is not medically necessary.

The Booklet-Certificate contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- The benefit payable will be reduced by $500 or 50% of the expense whichever is less, or your expenses may not be covered if the service or supply is not medically necessary.

Subrogation and Right of Reimbursement

The sub-section entitled "Subrogation and Right of Reimbursement", if included in the General Provisions part of your Booklet-Certificate, has been removed and does not apply to your plan of benefits.

Coordination of Benefits
Getting Started - Important Terms

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

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

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

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

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

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

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

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

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

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

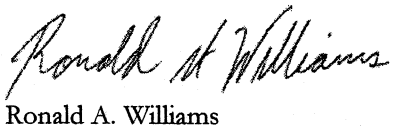
This Plan is any part of the policy that provides benefits for health care expenses.

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

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

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

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



Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Sarah Lawrence College
Group Policy No.:	GP-875727
Rider:	Florida ET Medical
Issue Date:	January 11, 2011
Effective Date:	November 1, 2010

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

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

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

Coverage for Dependent Children

To be eligible, a dependent child must be:

- Under 19 years of age; or
- Under age 25, as long as he or she solely depends on your support*; and
  - is living in your household, or
  - is a full-time or part-time student.

*Note: Dependent child eligibility ends at the end of the calendar year in which the child reaches the age of 25. Proof of student status is required each year.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any child whose parent is your child and your child is covered as a dependent under this Plan.
- Any other child with whom you have a parent-child relationship.

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

How and When to Enroll *(GR-9N 29-015 01-FL)*

Initial Enrollment in the Plan

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

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

Newborns are automatically covered for 60 days after birth. To continue coverage after 60 days, you will need to complete a change form and return it to your employer within the 60-day enrollment period.

Routine Physical Exams

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

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

Covered expenses for children for child health supervision services from birth through age 16 also include:

- An initial **hospital** check up; and
- Well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians. Included are:
  - A review and written record of the child's complete medical history.
  - Physical Examination.
  - Developmental and behavioral assessment.
  - Anticipatory Guidance.
  - Appropriate Immunization.
  - Laboratory Test.

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

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

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for physical exams.

Well Child Exams Includes coverage for immunizations	Refer to the Schedule of Benefits for details on the exam copay (if applicable) and coinsurance. No **deductible** applies.	Refer to the Schedule of Benefits for details on the coinsurance and deductible.
Child Immunizations Only	Refer to the Schedule of Benefits for details on the exam copay (if applicable) and coinsurance No **deductible** applies.	Refer to the Schedule of Benefits for details on the coinsurance and deductible. No **deductible** applies.

Routine Mammograms

Covered expenses include charges incurred for routine mammograms as follows:

Routine Mammogram for women

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

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

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

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

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

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

Cleft Lip or Palate Treatment *(GR-9N 11-155-01)*

(Dependent Children Under Age 18 only)
Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Oral surgery and facial surgery, including pre and post-operative care provided by a **physician**;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;

- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy provided by a **physician**, if the therapy is expected to restore or improve your ability to speak. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

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

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

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

In no event will the covered amount for Out-Of-Network charges be less than 50% of the covered amount for In-Network charges.

In no event will any Out-Of Network Deductible be more than four times any In-Network Deductible. If there is no Individual In-Network Deductible, any Out-Of-Network Individual Deductible cannot exceed $500 per individual.

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

Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, for up to 12 months.

In the case of maternity expense coverage, coverage will continue to be available to you for medical expenses directly relating to a pregnancy that began before coverage under this Policy ceased. Such benefits will be covered only for the period of that pregnancy.

Converting to an Individual Medical Insurance Policy *(GR-9N 31-040 01 FL)*

Eligibility

- You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical plan for any reason: except ceasing to contribute; or discontinued group health coverage is replaced by similar group health coverage within 31 days.

At the time of application, you will be offered a choice of at least two plans; the Standard Conversion Plan and another plan in which benefits are substantially similar to the level of benefits in a standard health benefit plan, as established pursuant to s. 627.6699(12).

You can only use the conversion option once. If your group plan allows retirees to continue medical coverage, and you wish to continue your plan, then the conversion privilege will not be available to you again.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

Features of the Conversion Policy

The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent's states of residence; and
- Offered by Aetna when you or your dependents apply under your employer's conversion plan.

However, coverage will not be the same as your group plan coverage. Generally, the coverage level may be less, and there is an applicable overall lifetime maximum benefit.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy.

Limitations

You or your dependents do not have a right to convert if:

- You or your dependents are eligible for Medicare. Covered dependents not eligible for Medicare may apply for individual coverage even if you are eligible for Medicare.
- Coverage under the plan has been in effect for less than three months.
- A lifetime maximum benefit under this plan has been reached. For example:
  - If a covered dependent reaches the group plan's lifetime maximum benefit, the covered dependent will not have the right to convert. If you or your dependents have remaining benefits, you are eligible to convert.
  - If you have reached your lifetime maximum, you will not be able to convert. However, if a dependent has a remaining benefit, he or she is eligible to convert.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You apply for individual coverage in a jurisdiction where **Aetna** cannot issue or deliver an individual conversion policy.

Electing an Individual Conversion Policy

You or your covered dependents have to apply for the individual policy within 31 days after your coverage ends. You do not need to provide proof of good health if you apply within the 31 day period.

If coverage ends because of retirement, the 31 day application period begins on the date coverage under the group plan actually ends. This applies even if you or your dependents are eligible for benefits based on a disability continuation provision because you or they are totally disabled.

To apply for an individual medical insurance policy:

- Get a copy of the "Notice of Conversion Privilege and Request" form from your employer.
- Complete and send the form to **Aetna** at the specified address.

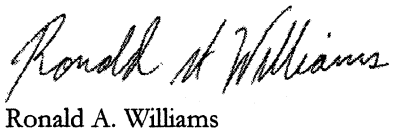
Your Premiums and Payments

Your first premium payment will be due at the time you submit the conversion application to **Aetna**.

The amount of the premium will be **Aetna's** normal rate for the policy that is approved for issuance in your or your dependent's state of residence.

When an Individual Policy Becomes Effective

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once **Aetna** receives and processes your completed application and premium payment.



Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)

The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Sarah Lawrence College
Group Policy No.:	GP-875727
Rider:	New Hampshire ET Medical
Issue Date:	January 11, 2011
Effective Date:	November 1, 2010

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

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

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

Coverage for Dependent Children

To be eligible, a dependent child must be:

- Unmarried; and
- Under 26 years of age.

Routine Mammogram

Even though not incurred in connection with an **illness** or **injury**, **covered expenses** include charges incurred by a female age 35 or over for a routine mammogram as follows:

- One baseline mammogram for a person 35 to 39 years of age.
- One mammogram every 1 to 2 years, even if no symptoms are present, for women 40 to 49 years of age.
- An annual mammogram for a person 50 years of age or older.

Diabetic Equipment And Outpatient Self-Management Training And Education Expenses *(GR-9N 11-135 01-NH)*

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

- Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;

- Test strips and tablets;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Certain expenses incurred in connection with the treatment of diabetes are **covered expenses**. Benefits for these expenses are provided to the same extent as benefits for any other illness.

Charges incurred in a **hospital**, convalescent or skilled nursing facility, or home health care will be paid at the applicable payment percentage.

If a **physician**, nurse practitioner, or clinical nurse specialist:

- diagnoses diabetes; or
- diagnoses a significant change in the person's diabetic symptoms or condition that requires a change in the person's self-management of the disease; or
- determines that a person who is a diabetic needs reeducation or refresher education;

charges for the following for the treatment of diabetes will be included as Other Medical Expenses; to the extent they are not already covered under any part of this Plan:

- insulin;
- oral agents;
- and medically appropriate or necessary equipment;

Also included as Other Medical Expenses are charges incurred for Diabetic Self-Management Education. "Diabetic self-management education" is training designed to instruct a person in self-management of diabetes, including medical nutrition therapy. It may include training in self care or diet. Such charges must be made by:

- a **physician**, nurse practitioner, clinical nurse specialist; or
- a pharmacist or dietitian who is legally qualified to provide diabetic management education.

Charges incurred for the following are not included as **covered expenses**:

- a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
- a general program not just for diabetics; or
- a program made up of services not generally accepted as necessary for the management of diabetes.

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

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

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

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

Covered expenses also include replacement of a prosthetic device if:

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

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

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, alopecia medicamentosa, alopecia totalis resulting from the treatment from any form of cancer or leukemia, or permanent hair loss of scalp hair due to injury. The treating physician must certify that the prosthesis is medically necessary. A benefit of no more than $350 per calendar year will be covered for scalp hair prosthesis worn suffered as a result of alopecia medicamentosa.
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

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

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

Treatment of Obesity and Morbid Obesity *(GR-9N 11-165-01)*

If you are at least 18 years of age, covered expenses include charges for the diseases and ailments caused by obesity and morbid obesity and treatment for such, including bariatric surgery, when the prescribing physician has issued a written order stating that treatment is medically necessary and in accordance with the patient qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Such treatment standards may include, but not be limited to, pre-operative psychological screening and counseling, behavior modification, weight loss, exercise regimens, nutritional counseling, and post-operative follow-up, overview, and counseling of dietary, exercise, and lifestyle changes. Covered expenses will be payable the same as any other illness.

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

Precertification

If this plan is determined to be the primary plan for purposes of the Coordination of Benefits provision of this Booklet-Certificate, **precertification** may be required as herein described. If this plan is determined to be the secondary plan for purposes of the Coordination of Benefits provision of this Booklet-Certificate, **precertification** shall not be required for benefits under this plan, however if the services do not meet **Aetna's** criteria for **medical necessity**, payment of secondary benefits may be denied.

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

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

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

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

The Precertification Process

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

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

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

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

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

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

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

- Certain types of medical care require **precertification**. It is your responsibility to obtain the necessary **precertification** from **Aetna**. If your medical expenses are not **precertified** by **Aetna**, If your medical expenses are not **precertified** by **Aetna**, the benefit payable will be reduced by $1,000 or 50% of the cost of the expense whichever is less, or the expense may not be covered if the service or supply is not medically necessary. This means you will be responsible to pay the unpaid balance of the bill. If **precertification** is denied, **Aetna** will notify you how the decision may be appealed. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Precertification* section for more information on the precertification process and what to do if your request for precertification is denied.

Important Note
If this plan is determined to be the primary plan for purposes of the Coordination of Benefits provision, failure to **precertify** will result in a reduction of benefits under this Booklet-Certificate. Please refer to the *Understanding Precertification* section for information on how to request precertification.

Autologous Bone Marrow Transplants *(GR-9N 11-191 01-NH)*

Covered expenses include charges made for the treatment of breast cancer by autologous bone marrow transplants according to protocols reviewed and approved by the National Cancer Institute.

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

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

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

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

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

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

Child Early Intervention Services *(GR-9N 11-005 02-NH)*

Covered expenses also include coverage for Child Early Intervention Services. Child Early Intervention Services include services rendered to your covered dependent child from birth to 3 years of age, who has an identified developmental disability. Such service will be covered when provided by:

- A speech-language pathologist;
- an occupational or physical therapist; and
- a clinical social worker.

Child Early Intervention Services *(GR-9N-11-010-02)*

Calendar Year Maximum	$3,200	$3,200
Aggregate Maximum over total 3 year period	$9,600	$9,600

Treatment of a Biologically Based Mental Disorder *(GR-9N 11-170 01-NH0*

Covered medical expenses for the effective treatment of **biologically based mental disorder** include those incurred:

- During a **stay** in a **hospital** or **residential treatment facility**;
- For **partial confinement treatment**; and
- For outpatient treatment.

Benefits are payable in the same way as those for any other disease. Coverage under this benefit does not include treatment of **other mental disorders**.

- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The copayment will be the lesser of the copayment and the pharmacy's usual and customary price of filling the prescription. The copayment is payable directly to the network pharmacy at the time the prescription is dispensed.

- After you pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** is based on the lesser of the **negotiated charge** and the pharmacy's usual and customary price of filling the prescription. You will not have to pay any balance bills above the **negotiated charge** for the **covered expense**.

Continuing Health Care Benefits

If Health Expense Coverage would terminate because:

- you terminate employment, except because of gross misconduct; or
- you cease to be in an Eligible Class;

coverage may be continued for you and your eligible dependents.

You must request continuation within 31 days of the later of the date your Employer notifies you of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

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

- The end of an 18 month period which starts on the date coverage would otherwise terminate; except that if you or your dependent provide notice to your Employer that you or your dependent has been determined to be disabled under Title II or XVI of the Social Security Act on the date coverage would have otherwise terminated, except for this section, coverage for that disabled person only will be continued, unless terminated for another reason, until the end of a 29 month period which starts on the date coverage would have otherwise terminated, except for this section.
- The date you become eligible for like group benefits.
- The end of the period for which any required contributions have been made.

Coverage for a dependent will not be continued beyond the date it would otherwise terminate.

Part II
If Health Expense Coverage would terminate because of discontinuance of the coverage involved as to employees of the Eligible Class of which you were a member, coverage, except Comprehensive Dental Expense Coverage, may be continued for you and your eligible dependents. You must request continuation within 31 days of the later of the date your Employer notifies you of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

Coverage will cease on the first to occur of:

- The date you are eligible for like group benefits.
- The end of the period for which any contributions have been made.
- The end of a period equal to 39 weeks, less the number of weeks your coverage was continued under this Plan during a strike, lockout or labor dispute. However, if coverage is being continued in accordance with Part I at the time coverage terminates as to your Eligible Class, coverage will be continued for up to the remainder of the 18 or 29 month period specified in Part I.

Part III
If any coverage being continued under Part I or Part II ceases because coverage has been continued for the maximum period, a personal policy may be applied for under the Conversion Privilege. This must be done within 31 days of the date coverage ceases.

A spouse from whom you are divorced may continue coverage in accordance with Part I or Part II; but not both. A spouse from whom you are legally separated and whose coverage would terminate because you failed to make the required contributions may continue coverage in accordance with Part II.

Continuation of Coverage For Your Spouse

Part I
If Health Expense Coverage for your dependent spouse would terminate due to divorce, the former spouse may continue to be covered. Your former spouse has to request continuation within 31 days after the later of the date your Employer notifies the spouse of the right to continue and the date he or she ceases to be eligible as a dependent.

Premium payments must be continued. Coverage will not continue beyond the first to occur of:

- The date the former spouse is eligible for like group benefits.
- The end of a 39 week period after:
  - the date dependent coverage ceases under this Plan for your Eligible Class; or if earlier,
  - the date you or your former spouse remarries.
- The end of the period for which any required contribution was made.
- The date your former spouse becomes eligible for Medicare if your former spouse was age 55 or over on the date coverage is first continued under this section.

Part II
If Health Expense Coverage for your dependent spouse would terminate because of divorce or because you ceased to make contributions for a spouse from whom you are legally separated, the spouse may continue the coverage then in force.

Written request for such continuation must be made within 31 days of the later of the date the Employer notifies the spouse of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

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

- The date the spouse becomes eligible for like group benefits.
- The end of a 36 month period which starts on the date of the divorce or the date contributions cease for a spouse from whom you are legally separated; except that if the coverage involved discontinues during such 36 month period as to employees of the Eligible Class of which you are a member, coverage will be continued, unless terminated for another reason, until the later of:
  - 39 weeks from the date of such discontinuance; and
  - the remainder of the 36 month period on the date of such discontinuance.
- The end of the period for which required contributions have been made.

Part III
If any coverage being continued under Part I or Part II ceases because coverage has been continued for the maximum period, a personal policy may be applied for under the Conversion Privilege. This must be done within 31 days of the date coverage ceases.

Continuation of Coverage For Your Dependents After Your Death

If you should die while covered under any part of this Plan, any Health Expense Coverage then in force for your dependents may be continued.

Written request for such continuation must be made within 31 days of the later of the date your employer notifies your dependents of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

Any dependent's coverage will not continue beyond the first to occur of:

- The end of a 36 month period which starts on the date of your death; except that if the coverage involved discontinues during such 36 month period as to employees of the Eligible Class of which you were a member, coverage will be continued, unless terminated for another reason, until the later of:
  - 39 weeks from the date of such discontinuance; and
  - the remainder of the 36 month period on the date of such discontinuance.
- The date the dependent becomes eligible for like group benefits.
- The end of the period for which any required contributions have been made.
- Coverage may also be provided under this Plan for your child, born after your death, as long as coverage for your other dependents is being continued.
- If any coverage being continued ceases because coverage has been continued for the maximum period, a personal policy may be applied for under the Conversion Privilege. This must be done within 31 days of the date coverage ceases.

Continuation of Coverage For Your Child

If Health Expense Coverage for your child would terminate because the child ceases to meet this Plan's definition of dependent, such child may continue the coveragethen in force.

Written request for such continuation must be made within 31 days of the later of the date your Employer notifies the child of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

Coverage will not continue beyond the first to occur of:

- The end of a 36 month period which starts on the date the child ceases to meet this Plan's definition of dependent; except that if the coverage involved discontinues during such 36 month period as to employees of the Eligible Class of which you are a member, coverage will be continued, unless terminated for another reason, until the later of:
  - 39 weeks from the date of such discontinuance; and
  - the remainder of the 36 month period on the date of such discontinuance.
- The date the child becomes eligible for like group benefits.
- The end of the period for which any required contributions have been made.
- If any coverage being continued ceases because coverage has been continued for the maximum period, a personal policy may be applied for under the Conversion Privilege. This must be done within 31 days of the date the coverage ceases.

Continuation of Coverage Due to a Labor Dispute

If your coverage under this Plan would cease because you cease work due to a strike, lockout or a labor dispute, and if the New Hampshire Insurance Code applies, you can arrange to continue your coverage (except Accidental Death and Dismemberment, Short Term Disability, Long Term Disability and Comprehensive Dental Expense Coverages) during your absence from work. Coverage may continue for up to 6 months after the date your compensation is suspended or terminated because of a strike, lockout or labor dispute.

Continuation will cease when the first of these events occurs:

- You fail to make the required contributions to your Employer.
- Your Employer fails to make the required contributions to Aetna.
- You go to work full time for another employer.
- The strike, lockout or labor dispute ends.
- The 6 month continuation period ends. However, after this 6-month period, you shall have the right to continue the benefits being continued under this paragraph for an additional 12 months as if you originally had elected the extension period provided under the Continuing Health Care Benefit section subject to the same conditions. At the end of the additional 12 months, you shall have the right, if the group insurance is no longer available, to convert to an individual policy. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.
- The monthly premium required by Aetna for each person's coverage will be the applicable rate in effect on the date you cease work. Aetna has the right to change premium rates under the terms of this Plan at any time during any continuation of coverage.

Handicapped Dependent Children *(GR-9N 31-015 02-NH)*

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

Your child is fully handicapped if:

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

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

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Your child ceases to be financially dependent on you; or you or your estate is no longer chargeable for your dependent's care.
- Premiums cease to be paid for your child's coverage.Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

If:

- any health coverage for dependents under this plan replaces health coverage under any group or blanket plan; and
- the prior plan contained a handicapped dependent children provision;

then any child to whom that provision applied who was covered under the prior plan on the day before the effective date of this Plan will be entitled to coverage under this Plan subject to terms of this provision.

Any child whose coverage is continued under this section will be entitled to any Medical Conversion Privilege contained in this Plan if the incapacity ceases.

Continuation of Coverage on a Loss of Coverage Due to a Bankruptcy Proceeding

If your health coverage as a retired employee would terminate or be substantially eliminated due to your former Employer commencing a bankruptcy proceeding under Title 11, United States Code, or within the 12 month period prior to or following such a proceeding, you may be eligible to elect to continue coverage for yourself and your dependents or your dependents may each be eligible to elect to continue his or her own coverage.

Written request for such continuation must be made within 31 days of the later of the date your Employer notifies you or your dependents of the right to continue and the date bankruptcy proceedings begin. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

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

- The end of a 36 month period which starts on the date coverage would otherwise terminate.
- The date you or your dependent becomes eligible for like coverage under this Plan.
- The end of the period for which any required contribution was made.
- The date of the first Medicare open enrollment period following the date you or your dependent became ineligible for the group plan.

Continuation of Coverage For Your Dependents After You Become Eligible For Medicare

If coverage for your dependents would terminate because you become eligible for Medicare, any Health Expense Coverage,then in force for your dependents may be continued.

Written request for such continuation must be made within 31 days of the later of the date your Employer notifies your dependents of the right to continue and the date coverage would otherwise terminate. The request must include an agreement to pay up to 102% of the cost to this Plan. Premium payments must be continued.

Coverage for a dependent will not continue beyond the first to occur of:

- The end of a 36 month period which starts on the date you become eligible for Medicare; except that if the coverage involved discontinues during such 36 month period as to employees of the Eligible Class of which you were a member, coverage will be continued, unless terminated for another reason, until the later of:
  - 39 weeks from the date of such discontinuance; and
  - the remainder of the 36 month period on the date of such discontinuance.
- The date the dependent becomes eligible for like group benefits.
- The end of the period for which any required contributions have been made.
- If any coverage being continued ceases because coverage has been continued for the maximum period, a personal policy may be applied for under the Conversion Privilege. This must be done within 31 days of the date coverage ceases

Converting to an Individual Medical Insurance Policy *(GR-9N 31-040 01-NH)*

Eligibility

You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical plan because:

- You terminate your employment;
- You are no longer in an eligible class;
- Your dependent no longer qualifies as an eligible dependent;
- Any continuation coverage required under federal or state law has ended; or
- You retire and there is no medical coverage available.

You can only use the conversion option once. If your group plan allows retirees to continue medical coverage, and you wish to continue your plan, then the conversion privilege will not be available to you again.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

Features of the Conversion Policy

The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent's states of residence; and
- Offered by **Aetna** when you or your dependents apply under your employer's conversion plan.

However, coverage will not be the same as your group plan coverage. Generally, the coverage level may be less, and there is an applicable overall lifetime maximum benefit.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy.

Limitations

You or your dependents do not have a right to convert if:

- Medical coverage under the group contract has been discontinued.
- You or your dependents are eligible for Medicare (Title XVIII of the Social Security Act, as amended). Covered dependents not eligible for Medicare may apply for individual coverage even if you are eligible for Medicare.
- Coverage under the plan has been in effect for less than 60 days.
- A lifetime maximum benefit under this plan has been reached. For example:
  - If a covered dependent reaches the group plan's lifetime maximum benefit, the covered dependent will not have the right to convert. If you or your dependents have remaining benefits, you are eligible to convert.
  - If you have reached your lifetime maximum, you will not be able to convert. However, if a dependent has a remaining benefit, he or she is eligible to convert.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You apply for individual coverage in a jurisdiction where **Aetna** cannot issue or deliver an individual conversion policy.
- You or your covered dependents are eligible for, or have benefits available under, another plan that, in addition to the converted policy, would either match benefits or result in over insurance. Examples include:
  - Any other hospital or surgical expense insurance policy;
  - Any hospital service or medical expense indemnity corporation subscriber contract;
  - Any other group contract; or
  - Any statute, welfare plan or program.

Electing an Individual Conversion Policy

You or your covered dependents have to apply for the individual policy within 31 days after your coverage ends. You do not need to provide proof of good health if you apply within the 31 day period.

If coverage ends because of retirement, the 31 day application period begins on the date coverage under the group plan actually ends. This applies even if you or your dependents are eligible for benefits based on a disability continuation provision because you or they are totally disabled.

To apply for an individual medical insurance policy:

- Get a copy of the "Notice of Conversion Privilege and Request" form from your employer.
- Complete and send the form to **Aetna** at the specified address.

Your Premiums and Payments

Your first premium payment will be due at the time you submit the conversion application to **Aetna**.

The amount of the premium will be **Aetna's** normal rate for the policy that is approved for issuance in your or your dependent's state of residence.

When an Individual Policy Becomes Effective

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once **Aetna** receives and processes your completed application and premium payment.

Payment of Benefits *(GR-9N 32-025 02-NH)*

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

Medical or hospital benefits will be paid within 30 calendar days upon receipt of a clean non-electronic claim or 15 calendar days upon receipt of a clean electronic claim. A "clean claim" means a claim for payment of covered health care expenses that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the insurer's published filing requirements. An "electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the insurer and, if covered by the Health Insurance Portability and Accountability Act (HIPAA), is in such form and substance to be in compliance with such act.

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

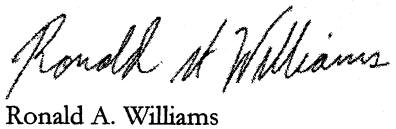
Physician *(GR-9N 34-080 04)*

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage; this includes a midwife certified under New Hampshire law, contingent upon services being provided in a licensed health care facility or at home and within the scope of practice of a certified midwife.
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.



Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Sarah Lawrence College
Group Policy No.:	GP-875727
Rider:	New Jersey ET Medical
Issue Date:	January 11, 2011
Effective Date:	November 1, 2010

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

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

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

Dependents

The term "spouse" shall include a Civil Union partner as defined by New Jersey State Law. In addition, if applicable, any references under this Booklet-Certificate made to "marriage", "husband", "wife", "family", "immediate family", "dependent", "next of kin", "widow", "widower", "widowed" or another word which in a specific context denotes a marital or spousal relationship, the same shall include a Civil Union. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be valid in New Jersey.

If you are a civil union partner, who is eligible for COBRA continuation of coverage you may elect COBRA continuation of coverage for you and your eligible dependents, including a civil union partner. However, an eligible dependent who is a civil union partner, may not make a COBRA continuation of coverage election for themselves and their eligible dependents after any event that would otherwise give rise to COBRA rights, as they do not meet the federal definition of a "qualified beneficiary" under COBRA rules.

Ronald A. Williams

Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Sarah Lawrence College
Group Policy No.:	GP-875727
Rider:	Oregon ET Medical
Issue Date:	January 11, 2011
Effective Date:	November 1, 2010

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

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

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

Obtaining Coverage for Dependents *(GR-9N 029-010 02 OR)*

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

- Your legal spouse; or
- Your domestic partner who meets the rules outlined in the *Coverage for Domestic Partner* section below; and
- Your dependent children.

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

Coverage for Domestic Partner *(GR-9N 29-010 01-NY)*

To be eligible for coverage, you and your domestic partner will need to:

- meet the requirements under Oregon law for entering into a domestic partnership; and
- jointly execute and register a Declaration of Domestic Partnership with the county clerk; or
- complete and sign a "Declaration of Domestic Partnership" which is acceptable to your Employer.

Prosthetic Devices *(GR-9N-11-110-02 OR)*

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

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

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

Covered expenses also include replacement of a prosthetic device if:

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

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

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- Cochlear implants, including bilateral implantation;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

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

- any item listed in the *Exclusions* section.

Chemotherapy

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

Radiation Therapy Benefits

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

Outpatient Infusion Therapy Benefits

Covered expenses include charges made on an outpatient basis for infusion therapy by:

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

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

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

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

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

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

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

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

Important Reminder
Refer to the *Schedule of Benefits* for details on any applicable **deductible**, **coinsurance** and maximum benefit limits.

Educational services:

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

Health Insurance Portability *(GR-9N-31-040-01 OR)*

Eligibility

You and your covered dependents may apply for an individual health insurance portability policy if you lose coverage under the group health plan because:

- You were continuously covered under this group health plan or any other group health plan issued in Oregon for a period of 180 days or more prior to loss of coverage; or
- You have aggregate creditable coverage of 18 months or more prior to loss of coverage; and
- Your and your covered dependents are Oregon residents at the time of application for an individual health insurance portability policy.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended.

Features of the Portability Policy

You have a choice of either a low cost benefit plan or a prevailing benefit plan:

- The prevailing benefit plan reflects the benefit coverage that is prevalent in the group health insurance market.
- The low cost benefit plan emphasizes affordability.

However, coverage will not be the same as your group plan coverage. Generally, the coverage level may be less, and there is an applicable overall lifetime maximum benefit.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy.

Limitations

You or your dependents do not have a right to an individual health insurance portability policy if at the time you apply for this coverage:

- You or your dependents are eligible for Medicare. Covered dependents not eligible for Medicare may apply for individual coverage even if you are eligible for Medicare;
- Coverage under the plan has been in effect for less than three months;
- You or your covered dependents are covered under another health benefit plan;
- You or your covered dependents are covered under COBRA continuation of coverage; or
- A lifetime maximum benefit under this plan has been reached. For example:
  - If a covered dependent reaches the group plan's lifetime maximum benefit, the covered dependent will not have the right to elect individual portability coverage. If you or your dependents have remaining benefits, you are eligible to elect individual portability coverage.
  - If you have reached your lifetime maximum, you will not be able to elect an individual portability policy. However, if a dependent has a remaining benefit, he or she is eligible to elect an individual portability policy.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You apply for individual coverage in a jurisdiction where **Aetna** cannot issue or deliver an individual portability policy.
- You or your covered dependents are eligible for, or have benefits available under, another plan that, in addition to the individual portability policy, would either match benefits or result in over insurance. Examples include:
  - Any other **hospital** or surgical expense insurance policy;
  - Any **hospital** service or medical expense indemnity corporation subscriber contract;
  - Any other group contract; or
  - Any statute, welfare plan or program.

Electing an Individual Portability Policy

You or your covered dependents have to apply for the individual health insurance policy within 63 days after your coverage ends.

If coverage ends because of retirement, the 63 day application period begins on the date coverage under the group plan actually ends. This applies even if you or your dependents are eligible for benefits based on a disability continuation provision because you or they are totally disabled.

To apply for an individual health insurance policy:

- Get a copy of the "Notice of Conversion Privilege and Request" form from your employer.
- Complete and send the form to **Aetna** at the specified address.

Your Premiums and Payments

Your first premium payment will be due at the time you submit the conversion application to **Aetna**.

The amount of the premium will be **Aetna's** normal rate for the policy that is approved for issuance in your or your dependent's state of residence.

When an Individual Policy Becomes Effective

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once **Aetna** receives and processes your completed application and premium payment.

Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Sarah Lawrence College
Group Policy No.:	GP-875727
Rider:	Pennsylvania ET Medical
Issue Date:	January 11, 2011
Effective Date:	November 1, 2010

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

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

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

Nutritional Supplements

Covered Expenses include charges incurred for nutritional supplements (formulas) as **Medically Necessary** for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a **Physician**.

Nutritional Supplement Services shall be exempt from any deductible provision.

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

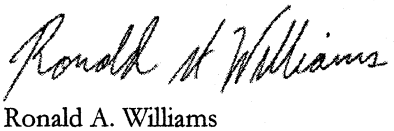
Covered expenses include charges incurred for routine cancer screening as follows:

- Routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologist; and
- 1 annual gynecological exam including pelvic examination and clinical breast exam.

Routine Pap smears and routine gynecological exams shall be exempt from any Network deductible provision.

Wellness *(GR-9N 11-005 01 NY)*
Covered expenses include Child Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control.

Child immunizations shall be exempt from any deductible provision.



Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Certificate Rider *(GR9000-R CTR)*

Policyholder:	Sarah Lawrence College
Group Policy No.	GP-875727
Rider	New York Contraceptive Rider
Issue Date	January 11, 2011
Effective Date	November 1, 2010

The following summarizes changes made in your Certificate of Insurance. This Rider is effective on the date shown above.

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 other group plan sponsored by your Employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Ronald A Williams

President and Chief Executive Officer

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment *(GR-9N-Appeals 01-01 03)*

Policyholder:	Sarah Lawrence College
Group Policy No.:	GP-875727
Rider:	New York Complaint and Appeals Health Rider
Issue Date:	January 11, 2011
Effective Date:	November 1, 2011

Complaint and Appeals - Health Coverage

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

The following Appeals Procedure provisions replace the same provisions in your Certificate of Insurance, or any amendments previously issued to you.

Appeals Procedure

Definitions

Adverse benefit determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit because it is determined to be experimental or investigational or not medically necessary or appropriate.

Such **adverse benefit determination** may be based on, among other things:

- Your eligibility for coverage;
- The results of any Utilization Review activities (determination as to whether or not an admission, extension of stay, or other health care service or supply is **medically necessary**, based on the information provided).

If applicable, denials of out-of-network claims on the basis that an out-of-network service is not materially different than an in-network service shall not constitute an **adverse benefit determination**.

Appeal: An oral or written request to Aetna to reconsider an **adverse benefit determination**.

Health care provider: A health care professional or facility licensed pursuant to New York law or licensed, registered or certified by another state.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment or provide additional services or home health care services following discharge from an inpatient hospital admission.

Expedited Appeal: Appeal of an **adverse benefit determination** involving (1) continued or extended health care services, procedures and treatments or additional services for a covered person undergoing a course of continued treatment prescribed by a health care provider or home health care or rehabilitation facility services following discharge from an inpatient hospital admission, or (2) an **adverse benefit determination** in which the health care provider believes an immediate appeal is warranted, except any retrospective determination, and (3) for an **adverse benefit determination** involving an urgent care claim.

Grievance: A request for review of a determination, other than a determination meeting the definition of **adverse benefit determination**.

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

Post-Service Claim: Any claim that is not a "Concurrent Care Claim Extension," an "Urgent Care Claim" or a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment with respect to which a delay: (a) could seriously jeopardize the life or health of the person or the ability of the person to regain maximum function; or (b) in the opinion of a physician with knowledge of the person's medical condition would subject the person to severe pain that cannot be adequately managed without the requested treatment.

Out-of-Network Denial: A denial of a request for preauthorization to receive a health service from an out-of-network provider on the basis that such service is not materially different from a health service available in-network. The Notice of denial of such out-of-network service shall include information explaining what information must be submitted to appeal the denial.

Rare Disease: A life threatening or disabling condition or disease that: (1)(a) is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (b) affects fewer than 200,000 United States residents per year; and (2) for which there does not exist a standard health service or procedure covered by the plan that is more clinically beneficial than the requested health service or treatment.

Claim Determinations – Group Health Coverage

Pre-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 3 business days after receipt of the necessary information. In the event you fail to provide all of the necessary information for Aetna to make a claim determination, Aetna will request such information within 3 days of receipt of the claim. Aetna will allow you 45 days to submit the necessary information, and will make a claim determination within 3 business days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify you of the decision within 15 days. Aetna will notify you or your designee and your **Health Care Provider** of the determination by telephone and in writing. Notification will include the total of approved services, the date of the onset of services and the next review date.

With respect to Pre-Service Urgent Care Claims, Aetna will make a notification by telephone and in writing within 24 hours after receipt of the claim. If more information is needed, Aetna will request it within 24 hours. You or your designee and your **Health Care Provider** will have 48 hours to submit the needed information. Aetna will make a determination and provide notice to you or your designee and your **Health Care Provider** by telephone and in writing within 48 hours of the earlier of Aetna's receipt of the information or the end of the 48 hour period after Aetna's request of the information.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, Aetna will make notification of a claim determination by telephone and in writing to you, your designee and your **health care provider** as soon as possible, but no later than one day after receipt of the necessary information, or 15 days from receipt of the claim. With respect to home health care services following an inpatient hospital admission, Aetna will make the notification no later than 72 hours after receipt of the necessary information when the day subsequent to the request falls on a weekend or a holiday. But, coverage shall not be denied on the basis of medical necessity or lack of authorization while the decision is pending.

With respect to Concurrent Claims that involve urgent matters, Aetna will make a determination and will notify you or your designee and your **Health Care Provider** by telephone and in writing within 24 hours after receipt of the request, if the request for additional information is made at least 24 hours prior to the end of the period for which benefits have been approved. Requests that are not made within this time will be determined within the timeframes for Pre Service Urgent Care Claims. It Aetna has approved a course of treatment, Aetna will not reduce or terminate the approved services before giving you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

Post-service Claims

Aetna will make notification of a claim determination in writing as soon as possible but not later than 30 calendar days after receipt of the claim. In the event you fail to provide all of the necessary information for Aetna to make a claim determination, Aetna will allow you 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify you of the decision within 15 days.

The Notice of **adverse benefit determination** will include:

- The reasons for the **adverse benefit determination**, including reference to specific plan provisions upon which the determination is based and the clinical rationale, if any;
- A description of the plan's review procedures, including a statement of claimants' rights to bring a civil action
- Instructions on how to start the appeals, expedited appeals and external appeals process;
- Notice of the availability, upon request, of the clinical review criteria used to make the **adverse benefit determination**. This notice will also specify what necessary additional information, if any, must be provided to, or obtained by, Aetna in order to render a decision on **appeal**.
- The Notice will be sent to you, your designee and your **Health Care Provider**.

In the event that Aetna renders an **adverse benefit determination** without first attempting to discuss the matter with the insured's **health care provider** who specifically recommended the service, procedure or treatment, the **health care provider** will have the opportunity to request a reconsideration of the adverse benefit determination. Except for post-service claims, such reconsideration will occur within one business day of receipt by Aetna of the request. If the **adverse benefit determination** is upheld, Aetna will provide notice, as described above.

If Aetna does not render a decision within the period set forth above, you may consider this to be an **adverse benefit determination**, subject to **appeal**.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about an **in-network provider (if applicable)** you must call or write Aetna Customer Service. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 15 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

By calling Customer Service. Aetna's Customer Service telephone number is on your ID card. If you are required to leave a recorded message, your message will be acknowledged within one business day after the call was recorded.

For written complaints, an acknowledgement letter will be sent to you within 15 days of Aetna's receipt of the **complaint**. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.

Appeals of Out-of-Network Denials (if applicable)

You may appeal an out-of-network denial based on the fact that an alternate service is available in-network by submitting:

- a written statement from your **physician** that the service is materially different from the health service the plan approved to treat your medical needs.
- two documents from available medical and scientific evidence, stating that such service is likely to be more clinically beneficial than the alternate in-network service and the adverse risk would not be substantially increased.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your level one **appeal**. Your **appeal** may be submitted orally or in writing. The request should include:

Your name;
Your employer's name;
A statement from your physician;
A copy of Aetna's notice of an **adverse benefit determination**;
Your reasons for making the **appeal**; and
Any other information you would like to have considered.

Send in your **appeal** to Customer Service at the address shown on your ID Card, or call in your **appeal** to Customer Service using the toll-free telephone number shown on your ID Card.

You may also choose to have an authorized designee make the **appeal** on your behalf by providing written consent to Aetna. Your **health care provider** may make the appeal in connection with the **adverse benefit determination** for a **post service claim**.

Level One Appeal

A level one **appeal** of an **adverse benefit determination** shall be decided by Aetna personnel not involved in making the **adverse benefit determination**.

Expedited Appeals
Aetna has established an expedited **appeals** process for adverse **benefit determinations** involving **urgent care** claims, **concurrent care claim extensions** and **pre-service claims**. Aetna will render a decision involving **urgent care, concurrent claim extension** and **pre-service claims** within the earlier of 72 hours of receipt of the **appeal**, or 2 business days from the receipt of the necessary information to conduct the **appeal**.

Pre-Service Claims (other than those subject to an Expedited Appeal)
Aetna shall issue a decision within 15 days of receipt of the **appeal**.

Post-Service Claims
Aetna shall issue a decision within the earlier of 15 days of receipt of the necessary information to conduct the **appeal** or 30 days of receipt of the request for an **appeal**.

The notice of the appeal determination will include:

- If the **adverse benefit determination** is upheld, the reason for the determination, including the clinical rationale for it; and
- A notice of your right to an external appeal, together with information and a description of the external **appeals** process. You also have the option to request a Level 2 **appeal** from Aetna.

If Aetna does not render an appeals determination for a Standard or Expedited **appeal** within the timeframes set forth above, the **adverse benefit determination** will be reversed.

Level Two Appeal

If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, you or your authorized representative have the option to file a level two **appeal** or request an External Appeal. The Level Two **appeal**, if requested, must be submitted within 60 calendar days following the receipt of notice of a level one **appeal** determination. Please note that that if you decide to pursue a Level Two **appeal** and wait for a decision from Aetna, you may miss the deadline to request an External Appeal from the New York State Insurance Department. Also, you may wish to end your Level Two **appeal** once you receive notice from the New York State Insurance Department that your request for an External Appeal has been received and is being sent out for review.

A level two **appeal** of an **adverse benefit determination** of an **expedited appeal** shall be decided by Aetna personnel not involved in making the **adverse benefit determination**. A level two **appeal** of an **adverse benefit determination** of a **pre-service claim** or a **post-service claim** will be reviewed by the Aetna Appeals Committee.

Expedited Appeals (Urgent Care Claims, Concurrent Care Claims Extensions and Pre-Service Claims)
Aetna shall issue a decision within 24 hours of receipt of the request for a level two **appeal** for these claims.

Pre-Service Claims (other than those subject to an Expedited Appeal)
Aetna shall issue a decision within 15 calendar days of receipt of the request for level two **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two **appeal**.

Grievances

You may submit a **grievance** to Aetna with respect to review of any determination other than an **adverse benefit determination**. The grievance must be submitted not less than 60 business days after receipt of the notice of the determination.

Aetna will acknowledge receipt of the **grievance** within 15 calendar days after its receipt by Aetna.

Grievance Determinations
Expedited Grievances
Aetna will resolve an expedited **grievance** within the lesser of 48 hours from receipt of the necessary information or 72 hours from receipt of the grievance when delay would significantly increase the risk to a person's health.

Standard Grievances
For other **grievances**, Aetna will resolve the grievance within the lesser of 30 days from receipt of the necessary information or 15 days from receipt of the grievance for pre-service claims grievances, or 30 days after receipt of a post service claims grievance.

Grievance Appeals
Expedited Grievances
Aetna will render a decision within 36 hours after receipt of the appeal.

Standard Grievances
For other **grievances**, Aetna will resolve the grievance within 15 days from receipt of the grievance appeal for pre-service claims grievances and 30 days from receipt of grievance appeal for post service claims grievances.

External Review

Your Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if Aetna has denied coverage on the basis that the a) service is not medically **necessary** or is an experimental or investigational treatment or (b) if applicable, such service is out-of network and an alternate is available in-network, you may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

Your Right to Appeal a Determination that a Service is not Medically Necessary

If Aetna has denied coverage on the basis that the service is not medically **necessary**, you may **appeal** to an External Appeal Agent if you satisfy the following criteria listed below:

- The service, procedure or treatment must otherwise be a Covered Medical Expense under this plan; and
- You must have received a final **adverse benefit determination** through the first level of Aetna's internal review process and Aetna must have upheld the denial or you and Aetna must agree in writing to waive any internal appeal.

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following criteria:

- The service must otherwise be a Covered Medical Expense under this plan; and
- You must have received a final **adverse benefit determination** through the first level of Aetna's internal **appeal** process and Aetna must have upheld the denial or you and Aetna must agree in writing to waive any internal **appeal**.

In addition, your attending **physician** must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the attending **physician**, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a dependent child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending **physician** must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered under this plan or one for which there exists a clinical trial (as defined by law) or **rare disease**. In the case of a **rare disease**, the attending **physician** may not be the treating **physician**.

In addition, your attending **physician** must have recommended at least one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Medical Expense (only certain documents will be considered in support of this recommendation – your attending **physician** should contact the State in order to obtain current information as to what documents will be considered acceptable) or in the case of a **rare disease**, based on the **physician's** certification and such other evidence as you, your designee, or the attending **physician** may present; or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

Your Right to Appeal a Determination that an Alternate Service is available In-Network (if applicable)

If Aetna has denied coverage on the basis that an alternate service is available in-network (other than a clinical trial, which is covered immediately above), you may **appeal** to an External Appeal Agent if you satisfy the following criteria listed below:

- The service, procedure or treatment must otherwise be a Covered Medical Expense under this plan; and
- You must have received a final **adverse benefit determination** through the first level of Aetna's internal review process and Aetna must have upheld the denial, or you and Aetna must agree in writing to waive any internal.
- The attending **physician** certifies that such out-of -network service is (i) materially different than the alternate in-network service; and (ii) based on two documents from available medical and scientific evidence, such service is likely to be more clinically beneficial than the alternate in-network service and the adverse risk would not be substantially increased.

For the purposes of this section, your attending **physician** must be a licensed, board certified or board eligible **physician** qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease. In the case of a **rare disease**, the attending **physician** may not be the treating **physician**.

The External Appeal Process

If, through the first level of Aetna's internal **appeal** process, you have received a final **adverse benefit determination** upholding a denial of coverage on the basis that the service is not medically **necessary** or is an experimental or investigational treatment, or (if applicable) an alternate service is available in-network, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and Aetna have agreed to waive any internal **appeal**, you have 45 days from the receipt of such waiver to file a written request for an external **appeal**. Aetna will provide an external appeal application with the final **adverse benefit determination** issued through the first level of Aetna's internal **appeal** process or its written waiver of an internal **appeal**.

You may also request an external **appeal** application from the New York State Department of Insurance at 1-800-400-8882. The completed application must be submitted to the New York State Department of Insurance at the address listed in the application. If you satisfy the criteria for an external **appeal**, the State will forward the request to a certified External Appeal Agent.

You will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Aetna based its denial, the External Appeal Agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If Aetna chooses to exercise this right, Aetna will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited **appeal** (described below), Aetna does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within thirty (30) days of receipt of the completed application. The External Appeal Agent may request additional information from you, your **physician** or Aetna. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending **physician** certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external **appeal**. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and Aetna by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns Aetna's decision that a service is not medically **necessary** or approves coverage of an experimental or investigational treatment or determines that the out-of-network service (if applicable) should be covered under the Plan, Aetna will provide coverage subject to the other terms and conditions of this Plan. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to you according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices; the costs of non-health care services; the costs of managing research; or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and Aetna. The External Appeal Agent's decision is admissible in any court proceeding.

Your Responsibilities

It is your responsibility to initiate the external **appeals** process. You may initiate the external **appeal** process by filing a completed External Appeal application with the New York State Department of Insurance. You or your designee may file an external **appeal** application; but if it's filed by your designee, you must consent to it in writing. The Department of Insurance may request from you written confirmation of the appointment of a designee. In addition, your attending **physician** has the right to pursue an external **appeal** of a retrospective **adverse claim determination**. To do so, the attending **physician** must complete an External Appeal application for health care providers. You must sign an acknowledgment of the request and a consent form to release any medical records.

Under New York State law, the completed request for **appeal** must be filed within 45 days of either: the date upon which you receive written notification from Aetna that it has upheld a denial of coverage; or the date upon which you receive a written waiver of any internal **appeal**. Aetna has no authority to grant an extension of this deadline.

Covered Services and Exclusions

In general, this plan does not cover experimental or investigational treatments. However, this plan shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with this section. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to you according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this policy for non-experimental or non-investigational treatments provided in such clinical trial.

APPEALS OF ADMISSIONS FOR OR PROVISIONS OR CONTINUATION OF ACCESS TO END OF LIFE CARE FOR PERSONS DIAGNOSED WITH ADVANCED CANCER

The following applies if a person: (i) has been diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified by the person's participating provider); and (ii) the participating provider, in consultation with the medical director of a facility specializing in the treatment of terminally ill patients and licensed pursuant to article 28 of the public health law, has determined that the person's care would be appropriately provided by such facility.

In the event **Aetna** disagrees with the admission of or provision or continuation of care of the person by the facility, **Aetna** must initiate an expedited external appeal as described above. However, until a decision is rendered, such admission for, provision of or continuation of the care by the facility will not be denied, and **Aetna** will continue to provide such coverage. The decision of the external appeals agent will be binding on all parties.

Aetna will keep records of your complaint for 7 years.

Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Massachusetts Involuntary Disenrollment Rider

Policyholder:	Sarah Lawrence College
Group Policy No.:	GP-875727
Rider No.:	MA-02
Issue Date:	January 11, 2011
Effective Issue Date:	November 1, 2010

The group policy specified above has been amended. The following summarizes the changes in the group policy and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

The following information is being provided to covered persons as required by the Massachusetts Managed Care Consumer Protections and Accreditation of Carriers Regulation 211 CMR 52.00.

The entire premiums charged to the Policyholder for the cost of health coverage under your plan of benefits are stated below. The amount that you contribute, if any, towards the cost of this health coverage is determined by the Policyholder.

Summary of Monthly Billing Rates:

- **Premium Rates**

The current premium rates for all of the Accident and Health Coverages provided under this policy are on record with both Aetna and the Policyholder.

The premium rates shown above will become effective on November 1, 2010 and will remain in effect until December 31, 2011 in the absence of any material modifications made to the plan of benefits.

In accordance with the terms of the Group Policy, the Policyholder is expected to make premium payments to Aetna on the monthly premium due date. A grace period of 30 days after the due date will be allowed the Policyholder for the payment of each premium. Aetna has the right to terminate the Group Policy as to all or any class of employees of the Policyholder at any time after the end of the grace period if any premium; fee; charge; or rate for the employee's coverage has not been paid. This right is subject to the terms of any laws or regulations.

Termination of Coverage Disclosure

The Massachusetts Office of Patient Protection requires that insurance carriers disclose the following data:

For the year 2008, Aetna terminated the coverage of .0000% Massachusetts insureds covered under a medical plan underwritten by Aetna Life Insurance Company for one or more of the following reasons:

- Significant misrepresentation or fraud against Aetna on the part of the covered person.
- The covered person committed an act of physical or verbal abuse which posed a threat to a Preferred Care Provider or other covered person. The commission of the act of physical or verbal abuse was unrelated to the covered person's physical or mental condition.

If you have any questions concerning the data disclosed above, please contact the Massachusetts Office of Patient Protection by:

Calling its toll-free telephone number 1-800-436-7757;
Sending a fax to 617-624-5046; or
Via the internet site: www.state.ma.us/dph/bhqm.

GR-96225

Ronald A. Williams
Chairman, Chief Executive Officer, and President

BENEFIT PLAN

Prepared Exclusively for
Sarah Lawrence College

Open Access Managed Choice (Open Access Gatekeeper PPO Plan)

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

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

We want you to know℠

Aetna

Table of Contents

Preface 1
Important Information Regarding Availability of Coverage
Coverage for You and Your Dependents 2
Health Expense Coverage 2
Treatment Outcomes of Covered Services
When Your Coverage Begins 3
Who Can Be Covered 3
Employees
Eligible Classes
Obtaining Coverage for Dependents
How and When to Enroll 4
Initial Enrollment in the Plan
Late Enrollment
Annual Enrollment
Special Enrollment Periods
When Your Coverage Begins 7
Your Effective Date of Coverage
Your Dependent's Effective Date of Coverage
How Your Medical Plan Works 8
Common Terms 8
About Your Gatekeeper PPO Medical Plan 8
Availability of Providers
How Your Gatekeeper PPO Medical Plan Works 9
Understanding Precertification
Services and Supplies Which Require Precertification:
Emergency and Urgent Care 13
In Case of a Medical Emergency
Coverage for Emergency Medical Conditions
In Case of an Urgent Condition
Coverage for an Urgent Condition
Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition
Requirements For Coverage 15
Clinical Review Criteria Requests
What The Plan Covers 17
Gatekeeper PPO Medical Plan 17
Wellness 17
Routine Physical Exams
Preventative Health Care Services Expenses
Early Intervention Services
Routine Cancer Screenings
Family Planning Services
Bone Mineral Density Measurement or Test, Drug and Devices
Vision Care Services
Limitations
Primary and Preventive Obstetric and Gynecological Care
Physician Services 20
Physician Visits
Surgery
Anesthetics
Hospital Expenses 21
Room and Board
Other Hospital Services and Supplies
Outpatient Hospital Expenses
Coverage for Emergency Medical Conditions
Coverage for Urgent Conditions
Alternatives to Hospital Stays 23
Outpatient Surgery and Physician Surgical Services
Birthing Center
Ambulatory Care
Home Health Care
Private Duty Nursing
Skilled Nursing Facility
Hospice Care
Other Covered Health Care Expenses 27
Acupuncture
Ambulance Service
Diagnostic and Preoperative Testing 28
Outpatient Diagnostic Lab Work and Radiological Services
Outpatient Preoperative Testing
Durable Medical and Surgical Equipment (DME) 28
Experimental or Investigational Treatment 29
Pregnancy Related Expenses 30
Prescription Drugs 30
Prosthetic Devices 31
Short-Term Rehabilitation Therapy Services 31
Cardiac and Pulmonary Rehabilitation Benefits
Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.
Reconstructive or Cosmetic Surgery and Supplies 33
Reconstructive Breast Surgery
Specialized Care 33
Chemotherapy
Radiation Therapy Benefits
Outpatient Infusion Therapy Benefits
Diabetic Equipment, Supplies and Education 34
Treatment of Infertility 35
Enteral Formulas 36
Transplant Services 37
Treatment of Mental Disorders and Substance Use 39
Treatment of Substance Abuse
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) 40
Medical Plan Exclusions 41
Your Pharmacy Benefit 42

How the Pharmacy Plan Works 42
Getting Started: Common Terms 42
Accessing Pharmacies and Benefits 43
Accessing Network Pharmacies and Benefits
Emergency Prescriptions
Availability of Providers
Cost Sharing for Network Benefits
When You Use an Out-of-Network Pharmacy
Cost Sharing for Out-of-Network Benefits
Pharmacy Benefit 44
Retail Pharmacy Benefits
Mail Order Pharmacy Benefits
Self-Injectable Drugs - Specialty Pharmacy
Network Benefits
Other Covered Expenses
Pharmacy Benefit Limitations
Pharmacy Benefit Exclusions
When Coverage Ends 48
When Coverage Ends for Employees
Your Proof of Prior Medical Coverage
When Coverage Ends for Dependents
Continuation of Coverage 50
Continuing Health Care Benefits
Continuing Coverage for Dependent Students on Medical Leave of Absence
Handicapped Dependent Children
Extension of Benefits 51
Coverage for Health Benefits
COBRA Continuation of Coverage 52
Continuing Coverage through COBRA
Who Qualifies for COBRA
Disability May Increase Maximum Continuation to 29 Months
Determining Your Premium Payments for Continuation Coverage
When You Acquire a Dependent During a Continuation Period
When Your COBRA Continuation Coverage Ends
Conversion from a Group to an Individual Plan
Converting to an Individual Medical Insurance Policy 54
Eligibility
Features of the Conversion Policy
Limitations
Electing an Individual Conversion Policy
Your Premiums and Payments
When an Individual Policy Becomes Effective
Coordination of Benefits - What Happens When There is More Than One Health Plan 57
When Coordination of Benefits Applies 57
Getting Started - Important Terms 57
Which Plan Pays First 58
How Coordination of Benefits Work 59
Right To Receive And Release Needed Information
Facility of Payment
Right of Recovery
When You Have Medicare Coverage 61
Which Plan Pays First 61
How Coordination With Medicare Works 61
General Provisions 63
Type of Coverage 63
Physical Examinations 63
Legal Action 63
Confidentiality 63
Additional Provisions 63
Assignments 64
Misstatements 64
Incontestability 64
Subrogation and Right of Reimbursement 64
Worker's Compensation 65
Recovery of Overpayments 66
Health Coverage
Reporting of Claims 66
Payment of Benefits 66
Records of Expenses 67
Contacting Aetna 67
Effect of Benefits Under Other Plans 67
Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage
Effect of Prior Coverage - Transferred Business 68
Glossary * 69

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

Preface

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

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

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

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

Group Policyholder:	Sarah Lawrence College
Group Policy Number:	GP-875727
Effective Date:	November 1, 2010
Issue Date:	January 11, 2011
Booklet-Certificate Number:	2

Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage *(GR-9N 02-005 02)*

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

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

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

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

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

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan

modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

Coverage for You and Your Dependents

Health Expense Coverage

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

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

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

Treatment Outcomes of Covered Services

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

When Your Coverage Begins

(GR-9N 29-005-01-NY)

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

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

Who Can Be Covered

Employees

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

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

Eligible Classes

You are in an eligible class if:

- You are a regular part-time or full-time employee, as defined by your employer.

Determining When You Become Eligible

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

On the Effective Date of the Plan

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

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your eligibility coverage date is the first day of the month coinciding with or next following the date you are hired.

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

Obtaining Coverage for Dependents *(GR-9N-29-010-02 NY)*

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

- Your legal spouse; or
- Your domestic partner who meets the rules set by your employer; and
- Your dependent children.

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

Coverage for Domestic Partner *(GR-9N 29-010 01-NY)*

To be eligible for coverage, you and your domestic partner will need to complete and sign a Declaration of Domestic Partnership.

Coverage for Dependent Children *(GR-9N-29-010-02 NY)*

To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
- Under age 26, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*.

*Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 12 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

An eligible dependent child includes:

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

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

Important Reminder

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

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

How and When to Enroll *(GR-9N 29-015 03 NY)*

Initial Enrollment in the Plan

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

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

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

Late Enrollment

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

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

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

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

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

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

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

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

Loss of Other Health Care Coverage

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

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

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

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

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

New Dependents

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

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

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

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

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

If You Adopt a Child

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

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

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

When You Receive a Qualified Child Support Order

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

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

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

If you do not request coverage for the child within the 31-day period, **Aetna** will nevertheless provide the coverage for the child and for you, if necessary, regardless of whether you request coverage within the 31 days or not.

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

When Your Coverage Begins

Your Effective Date of Coverage

Your coverage takes effect on the later of:

- The date you are eligible for coverage; or
- The date your enrollment is received;
- If you are considered a late enrollee, on the first day of the first calendar month following the end of the late entrant enrollment period during which you elect coverage.

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

Your Dependent's Effective Date of Coverage

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

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

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

How Your Medical Plan Works

(GR-9N-08-005-01 NY)

Common Terms

Accessing Providers

Precertification

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

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

Important Notes

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

Common Terms *(GR-9N-S-08-010-01) (GR-9N-S-08-05-01 NY)*

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

About Your Gatekeeper PPO Medical Plan *(GR-9N-08-020-01 NY)*

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

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

This Gatekeeper PPO plan provides access to covered benefits through a network of health care providers and facilities. These **network providers** have contracted with **Aetna**, an affiliate or third party vendor to provide health care services and supplies to **Aetna** plan members at a reduced fee called the **negotiated charge**. This Gatekeeper

PPO plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your **deductibles**, **copayments**, and payment percentage will generally be lower when you use participating **network providers** and facilities.

Some services and supplies may only be covered through **network providers**. Refer to the *Covered Benefit* sections and your *Schedule of Benefits* to determine if any services are limited to network coverage only.

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

Availability of Providers

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

Ongoing Reviews

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

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

How Your Gatekeeper PPO Medical Plan Works *(GR-9N 08-030-01)*

The Primary Care Physician: *(GR-9N 08-030-01)*

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

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

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

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

Changing Your PCP

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

Specialists and Other Network Providers

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

(GR-9N 08-035-01)

Important Note

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

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

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

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

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

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

- You will need to satisfy any applicable **deductibles** before the plan will begin to pay benefits.

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

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

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

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

- You will need to satisfy any applicable **deductibles** before the plan will begin to pay benefits.

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

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

Precertification

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

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

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

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

The Precertification Process

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

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

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

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

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

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

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

Services and Supplies Which Require Precertification *(GR-9N-08-065-04 NY)*

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital**;
- **Stays** in a **skilled nursing facility**;
- **Stays** in a **rehabilitation facility**;
- **Stays** in a **hospice** facility;
- Outpatient **hospice care**;
- **Stays** in a **Residential Treatment Facility** for treatment of mental disorders and substance abuse;
- **Partial Hospitalization Programs** for mental disorders and substance abuse;
- **Home health care**;
- Private duty nursing care;
- Intensive Outpatient Programs for mental disorders and substance abuse;
- Amytal interview;
- Applied Behavioral Analysis;
- Biofeedback;
- Electroconvulsive therapy;
- Neuropsychological testing;

- Outpatient detoxification;
- Psychiatric home care services;
- Psychological testing.

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

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

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

How Your Benefits are Affected

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

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

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

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

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

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

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

In Case of a Medical Emergency

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

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

- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur. Please refer to the *Schedule of Benefits* for specific details about the plan.

Coverage for Emergency Medical Conditions

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

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

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

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

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

Coverage for an Urgent Condition

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

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

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

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

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

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

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

Requirements For Coverage *(GR-9N S-09-005-01 NY)*

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

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

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

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

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

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

Clinical Review Criteria Requests

If you or your covered dependent needs additional information on a specific clinical issue, you may request a clinical review criteria by submitting written request to Aetna. The written request must contain the following information:

- Person's name; address; and telephone number.
- A request for the clinical review criteria; which Aetna would utilize in making a coverage determination involving a specific condition, treatment or device.

The written request should be sent to the following address:

Aetna
CRC Requests - Mail Code: F074
3 Independence Way
Princeton, NJ 08540

Aetna will take into consideration the person's individual situation in applying the clinical review criteria.

For questions, or further assistance, the person should call the Customer Services toll-free telephone number shown in the Identification Card.

Important Note

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

In case of a denial of coverage, you have full advantage of all appeal rights available under New York State insurance law.

What The Plan Covers

(GR-9N 11-005 01 NY)

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

Gatekeeper PPO Medical Plan

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

Wellness

Routine Physical Exams

Covered expenses include charges made by your **primary care physician** for routine physical exams for person's age 19 or more. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

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

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

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

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

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for physical exams.

Preventive Health Care Services Expenses *(GR 9 NS 11-005 01 NY)*

This plan will pay for charges for preventive health care services provided in connection with a routine physical exam of a dependent child under 19 years of age, as follows. These charges are not subject to deductible or any lifetime maximum benefit. These services may be provided in a **hospital** or **physician's** office.

An initial hospital checkup and well-child visits scheduled in accordance with the prevailing standards of a national association of pediatric physicians designated by the New York State commissioner of health.

At each visit, services in accordance with the prevailing clinical standards of the designated association, including:

- A medical history;
- a complete physical examination;
- developmental assessment;
- anticipatory guidance;
- appropriate immunizations;
- laboratory tests.

All necessary immunizations recommended by the Advisory Committee on Immunizations Practices of the U.S. Public Health Service and the Department of Health of The State of New York, and in accordance with the minimum benefits mandated by the State of New York.

Not covered are charges for:

- Services which are covered to any extent under any other part of the plan;
- Services for diagnosis or treatment of a suspected or identified illness or disease;
- Medicines or drugs;
- Appliances, equipment or supplies;
- Premarital exams; dental exams; hearing exams; or exams related in any way to employment.

Early Intervention Services Expenses

The plan will pay the following charges even though they may not be incurred in connection with an **injury** or **disease**. Benefits are payable on the same basis as any other sickness. They are included only for a dependent child:

- Until September 1 of the calendar year in which the child attains the age of 3 years; if the child is born between January 1 and August 31 of that calendar year.
- Until January 2 of the calendar year following the calendar year the child attains the age of 3 years; if the child is born between September 1 and December 31 of the preceding calendar year.

The dependent child must be certified by the New York Department of Health as eligible to participate in the Early Intervention Program. You must submit proof of such qualification with the initial claim.

Early Intervention Services Expenses
These are the charges incurred for Early Intervention Services.

Early Intervention Services: These are services, designed to offer a comprehensive array of educational, developmental, health and social services to eligible infants, children and their families as specified in program regulations. They include, but are not limited to, the following:

- Speech and language therapy given in connection with a speech impairment resulting from a congenital abnormality, disease or injury.
- Occupational or physical therapy expected to result in significant improvement of a body function impaired by a congenital abnormality, disease or injury.
- Clinical psychological tests or treatment.
- Skilled nursing services, on a part-time or intermittent basis, given by an R.N. or by an L.P.N.

Benefits paid for early intervention services will not be applied against any maximum lifetime or annual limits specified in this Booklet-Certificate. However, visit limitations and other terms and conditions of the Booklet-Certificate will continue to apply to early intervention services. Visits used for Early Intervention Services will not reduce the number of visits otherwise available under the coverage for such services.

Routine Cancer Screenings

The plan will pay for charges incurred for routine cancer screening, as follows:

Mammograms:

- Upon recommendation of a **physician**, a mammogram at any age for females having a history of breast cancer or who have a first degree relative with a prior history of breast cancer;
- A single baseline mammogram for covered females aged 35 through 39; and
- An annual mammogram for covered females aged 40 or older.

One gynecological exam, including Pap smear, every twelve months.

The following coverage for diagnostic screening of prostatic cancer:

- Standard diagnostic tests, including but not limited to a digital rectal exam and one prostate specific antigen (PSA) test at any age for males having a prior history of prostate cancer; and
- An annual standard diagnostic examination, including but not limited to a digital rectal examination and a prostate specific antigen test for males age 50 or more who are asymptomatic and for males age 40 or more with a family history of prostate cancer or other prostate cancer risk factors.

Fecal occult blood test, sigmoidoscopy, colonoscopy, double contrast barium enema.

Any age limits shown above do not apply to any person who is at high risk for the cancer being screened.

Family Planning Services *(GR-9N 11-005 01 NY)*

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

Covered expenses include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

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

Also see section on pregnancy and infertility related expenses on a later page.

Bone Mineral Density Measurement or Test, Drug and Devices *(GR-9N 11-085-NY)*

Covered expenses include charges incurred for bone mineral density measurements or tests, including drugs and devices, for individuals(a) meeting the criteria under the federal Medicare program or the National Institutes of Health; or (b) previously diagnosed as having osteoporosis or a family history of osteoporosis; or (c) with symptoms or conditions indicative of the presence or of significant risk of osteoporosis; or (d) on a prescribed drug regimen posing a significant risk of osteoporosis; or (e) with lifestyle factors to such a degree posing a significant risk of osteoporosis; or (f) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

Bone mineral density measurements or tests, drugs and devices include those covered under the federal Medicare program as well as those in accordance with the criteria of the National Institutes of Health, including dual energy X-ray absoptiometry.

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

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

- ***Routine*** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 12 consecutive month period.

Limitations

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

Primary and Preventive Obstetric and Gynecological Care *(GR-9N-11-018-01 NY)*

Covered expenses include charges made by any provider of obstetric and gynecological services of the **Covered Person's** choice for primary and preventive obstetric and gynecological care, or any other care, related to a pregnancy or to an acute gynecological condition.

The plan covers charges for 2 examinations for primary and preventive obstetric and gynecological care in any Calendar Year.

Physician Services *(GR 9N S 11-20 01 NY)*

Physician Visits

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

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by a qualified **physician** for a second surgical opinion on the need for surgery; and a second medical opinion by an appropriate specialist (including, but not limited to a specialist affiliated with a specialty care center for the treatment of cancer) in the event of a positive or negative diagnosis of cancer; or a recurrence or cancer; or a recommendation of a course of treatment for cancer. The opinion may be rendered by either a **network** or a **non-network** specialist.

Surgery

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

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

Anesthetics

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

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

Hospital Expenses *(GR 9N S 11-030 01 NY)*

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

Room and Board

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

Room and board charges also include:

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

Other Hospital Services and Supplies

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

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

- **Ambulance** services.
- **Physicians** and surgeons.
- Operating, cytoscopic and recovery rooms.
- Intensive or special care facilities and equipment.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy, chemotherapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, electrocardiographs, electroencephalographs, laboratory testing and diagnostic services.
- Medications, sera, biological and vaccines.
- Intravenous (IV) preparations, visualizing dyes.
- Discharge planning.
- Dressings and casts.

Outpatient Hospital Expenses

Covered expenses include **hospital** charges made for:

- Covered services and supplies provided by the outpatient department of a hospital;
- Hospital services rendered within 24 hours after an accidental injury; and
- X-ray and lab test in the outpatient department of the hospital, to the extent such services would be provided if an inpatient.

Important Reminders

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

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

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

(**NOTE**: The duration and any **stay** for patients undergoing a lymph node dissection or lumpectomy for treatment of breast cancer, or a mastectomy, will be as determined by the attending **physician**, in consultation with the patient.)

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

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

Coverage for Emergency Medical Conditions

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

The **emergency care** benefit covers:

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

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

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

Coverage for Urgent Conditions

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

Your coverage includes:

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

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

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

Outpatient Surgery and Physician Surgical Services

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

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

The surgery must meet the following requirements:

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

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

The following outpatient surgery expenses are covered:

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

Limitations

Not covered under this plan are charges made for:

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

Birthing Center *(GR-9N 11-045 01 NY)*

Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

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

Limitations

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

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

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

Ambulatory Care

Covered expenses include charges incurred for ambulatory care in a **hospital's** outpatient department or in a **physician's** office. Ambulatory care includes: services for diagnostic X-rays; laboratory and pathological examinations; physical and radiation therapy; services and medications used for non-experimental cancer chemotherapy and cancer hormone therapy.

The services and supplies must be:

- Related to and necessary for treatment or diagnosis of your **illness** or **injury**;
- Ordered by a **physician**;
- In the case of physical therapy, furnished for the same illness or injury for which you were hospitalized or for surgery (care must start no later than 6 months after discharge from the **hospital** or surgery and is limited to 365 days following surgery or discharge from the **hospital**).

Home Health Care *(GR 9 NS 11-050 01 NY)*

Covered expenses include charges for home health care services when ordered by a **physician** provided:

- The charges are made by a **home health care agency**; and
- The care is given under a **home health care plan**; and
- The care is given to you in your home while you are homebound.

Home health care expenses include charges for:

- Part-time or intermittent care by a **R.N.** or by a **L.P.N.**
- Part-time intermittent home health aide services provided in conjunction with and in direct support of patient care.
- Physical, occupational and speech therapy.
- Medical supplies, prescription drugs and medications and lab services by or for a **home health care agency** to the extent they would have been covered under this plan if you been confined in a **hospital** or **skilled nursing facility** (as defined in Title XVIII of the Social Security Act).

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit. Each 4 hours of home health aide services is one visit.

Limitations

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

- Services or supplies that are not part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family.
- Transportation
- Services that are for **custodial care**.

Important Reminders

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

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

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

Private Duty Nursing *(GR-9N S-11-065-01)*

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

The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in your medication;
- Treatment of an urgent or **emergency medical condition** by a **physician**;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An inpatient **stay**.

Limitations

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

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

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

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

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

Important Reminder

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

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

Limitations

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

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

Hospice Care *(GR 9 N S 11-070 01 NY)*

Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses

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

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

Outpatient Hospice Expenses

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

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

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

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

- Psychological counseling; and
- Dietary counseling.

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

- Daily **room and board** charges over the **semi-private room rate**.
- More than 5 visits for bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.
- Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.

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

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

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

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

- As a form of anesthesia in connection with a covered surgical procedure; and
- To treat an **illness**, **injury** or to alleviate chronic pain.

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

Ambulance Service *(GR 9 NS 11-080 01 NY)*
Covered expenses include the following:

Emergency Transportation
Covered expenses include charges made by an ambulance service, issued a certificate to operate under the New York Public Health Law, for **prehospital emergency medical services**. Payment under the Plan will be payment in full for the services provided. An ambulance service that is so reimbursed by the Plan will not seek any reimbursement from, or have any recourse against you, except for the collection of **copays**, **coinsurance** or **deductibles** for which you are responsible under the Plan.

"Prehospital emergency medical services" means the prompt evaluation and treatment of an emergency medical condition, and/or non-airborne transportation of a covered person from the place where he or she is injured or stricken by illness to the **hospital** where treatment is given. If the person utilizes non-airborne emergency transportation, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (1) placing the health of the covered person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others' in serious jeopardy; (2) serious impairment to such covered person's bodily functions; (3) serious dysfunction of any bodily organ or part of such covered person; or (4) serious disfigurement of such covered person.

Non-Emergency Transportation
Covered expenses include charges by a professional ambulance service for the necessary non-emergency transfer of a covered person via ground ambulance or a medical van.

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

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

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

Outpatient Diagnostic Lab Work and Radiological Services

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

Important Reminder
Refer to the *Schedule of Benefits* for details about any **deductible, coinsurance** and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

Outpatient Preoperative Testing

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

- The test are related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Reservations for a bed or for an operating room were made prior to the tests:
  - The test are completed within 7 days before your surgery;
  - The test are performed on an outpatient basis;
  - The test would be covered if you were an inpatient in a **hospital**;
  - The test are not repeated in or by the **hospital** or **surgery center** where the surgery will be performed;
  - Test results appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

Important Reminder

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the test, however surgery will ***not*** be covered.

Durable Medical and Surgical Equipment (DME) *(GR 9 NS 11-090 01 NY)*

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

The initial purchase of **DME** if:

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

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

Replacement of purchased equipment if:

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

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

Covered **DME** includes equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have an **illness** or **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment **does not** include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

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

Important Reminder
Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible**, **coinsurance** and benefit maximums.

Experimental or Investigational Treatment

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

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
  - You are treated in accordance with protocol.

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

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

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

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

Covered expenses include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

If the mother is discharged earlier, the plan will pay for two post-delivery home visits by a health care provider. This will not be subject to any deductible or copay and will not count toward the maximum number of visits under the home health care benefit.

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

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

Prescription Drugs *(GR-9N 11-110 01 NY)*

Covered expenses include charges made for outpatient **prescription drugs** and insulin when prescribed in writing by a **physician** to treat an **illness** or **injury**. The plan covers both **generic** and **brand-name prescription drugs**.

Also covered will be charges for a prescription drug for the treatment of a certain type of cancer if the drug has been prescribed for treatment of a cancer for which it has not been approved by the federal Food and Drug Administration, but the drug is recognized for the treatment of the specific type of cancer in one of the standard reference compendia, or in medical literature.

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

- any outpatient **prescription drug** covered or excluded from coverage under Aetna's **prescription drug** plan in accordance with the **prescription drug** coverage and exclusions sections of this Booklet-Certificate or any separately issued Booklet-Certificate.

Lifestyle/Performance Drugs

Coverage includes:

- Sildenafil Citrate, phentolamine, apomorphine and alprostadil in oral, and topical (which includes, but is not limited to gels, creams, ointments and patches) forms; or any other form, internally or externally, are covered; regardless of **medical necessity**. Coverage includes: any prescription drug in oral or topical form, that is in a similar or identical class; has a similar or identical mode of action; or exhibits similar, or identical outcomes.
- Coverage is limited to 4 pills, or other form; determined cumulatively among all forms for unit amounts; determined by **Aetna** to be similar in cost to: oral forms, per 30 day supply.

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

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

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

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

Covered expenses also include replacement of a prosthetic device if:

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

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

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made and fitted for you.

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

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

Short-Term Rehabilitation Therapy Services *(GR 9N-11-120 01 NY)*

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

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

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits.

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.

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

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

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

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

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

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

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

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered;
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;

- Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or **hospice facility except as stated above**;
- Services not performed by a **physician** or under the direct supervision of a **physician**;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your domestic partner;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Reconstructive or Cosmetic Surgery and Supplies *(GR-9N 11-125 01 NY)*

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

- Surgery to correct the result of an accidental **injury** provided the surgery occurs no more than 24 months after the **injury**. For a covered child, surgery will be covered up to age 18 or up to 24 months after the **injury**, whichever period is longer. **Injuries** that occur during surgical procedures or medical treatments are not considered accidental injuries, even if unplanned or unexpected.
- Surgical implantation or attachment of covered prosthetic devices.
- Surgery to correct a gross anatomical defect present at birth. The surgery will be covered if the defect results in severe facial disfigurement or significant functional impairment of a body part; and the purpose of the surgery is to improve function.

Reconstructive surgery which is incidental to or follows surgery for trauma, infection or other diseases of the involved part, or necessary due to a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

Reconstructive Breast Surgery

Covered expenses include (i) reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. (ii) surgery on the other breast to make it symmetrical with the reconstructed breast; and (iii) physical therapy to treat complications of mastectomy, including lymph edema, in as manner determined by you and your attending **physician**.

Specialized Care *(GR-9N S-11-135 01 NY)*

Chemotherapy

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

Radiation Therapy Benefits

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

Outpatient Infusion Therapy Benefits

Covered expenses include charges made on an outpatient basis for infusion therapy by:

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

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

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

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

- Enteral nutrition;
- Blood transfusions

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

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

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

Important Reminder
Refer to the *Schedule of Benefits* for details on any applicable **deductible, coinsurance** and maximum benefit limits.

Services Provided by a Center for Eating Disorders

Covered expenses include charges made by a comprehensive care center for eating disorders to provide a coordinated, individualized plan of care for individuals with eating disorders, including all necessary non-institutional, institutional and practitioner services and treatments, from initial patient screening and evaluation to treatment , follow-up care and support.

Eating disorder includes, but is not limited to: conditions such as anorexia nervosa, bulimia and binge eating disorder, identified as such in the ICD-9-CM International Classification of Disease or the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, or other medical and mental health diagnostic references generally accepted for standard use by the medical and mental health fields.

Diabetic Equipment, Supplies and Education *(GR-9N 11-35 01 NY)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of diabetes:

Services
Diabetes self-management education given by a **physician** (or any other licensed health care provider), including information on proper diets. Coverage is limited to visits made upon diagnosis of diabetes, where a **physician** diagnoses a significant change in the patient's symptoms or condition which requires changes in the patient's self-management, or where reeducation or refresher education is necessary.

Supplies

- Insulin;
- Insulin pumps and accessories;
- Syringes;
- Injections aids for the visually impaired;
- Test strips for glucose monitoring and visual reading and urine testing strips
- Blood glucose monitors, including those for the visually impaired
- Lancets;
- Insulin infusion devices;
- Oral agents for controlling blood sugar;
- Cartridges for the visually impaired;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.
- Any additional equipment and related supplies as may be medically necessary for the treatment of diabetes.

End of Life Care
Covered expenses include charges incurred by a covered person who has been diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified the patient's attending physician) for acute care services at an acute care facility specializing in the treatment of terminally ill patients. The person's attending **physician**, in consultation with the medical director of such facility, must determine that the patient's care would be appropriately provided by such facility. The facility must be licensed pursuant to New York State's public health law, or by the state in which it is located.

In the event Aetna disagrees with the admission of or provision or continuation of care of the covered person by the facility, and Aetna initiates an expedited external appeal, such admission of, provision of, or continuation of the care by the facility will not be denied, and Aetna continue to provide coverage until a decision is rendered. The decision will be binding on all parties.

Treatment of Infertility *(GR-9N S-11-135 01 NY)*

Basic Infertility Services
The plan will include charges made by a **physician** to diagnose and treat a correctable medical condition where the medical condition results in **infertility**.

Comprehensive Infertility Services
The plan covers charges made for **hospital**, surgical and medical care which would correct malformation, disease or dysfunction resulting in **infertility**. The **infertility** must not be caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.

Covered expenses will include, but are not limited to, the following services or supplies:

- Ovulation induction;
- Artificial insemination;
- Ultrasound;
- Post-coital test;
- Hysterosalpinogram;
- Laparoscopy;
- Sono-hysterogram;
- Blood tests;
- Endometrial biopsy;
- Hysteroscopy;
- Semen analysis;
- Testis biopsy; and
- **Prescription** drugs.

Limitations
Not covered are charges for:

- Purchases of donor sperm and any charges for the storage of any sperm;
- The purchase of donor eggs and any charges associated with care of the donor required for donor egg retrieval, transfers or gestational carriers;
- Charges associated with cryopreservation, or storage of cryopreserved embryos, including but not limited to office visits, hospital charges, ultrasounds and lab tests;
- Reversal of elective sterilization;
- Sex change procedures;
- Cloning;
- Gestational carrier programs (surrogate parenting) for you or the gestational carrier;
- Prescription drugs used for the treatment of an excluded treatment or procedure, including injectable medications;
- Home ovulation prediction kits;
- In-vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; and intracytoplasmic sperm injection;
- Frozen embryo transfers; including thawing;
- Procedures deemed experimental in accordance with the standards of the American Society for Reproductive Medicine.

Important Reminder
Refer to the *Schedule of Benefits* for details about the **copays, deductibles** and maximums that apply to these services.

Enteral Formulas *(GR-9N S- 11-085-NY)*

Covered expenses include charges incurred for enteral formulas for home use and modified solid food products that are low in protein or which contain protein, which are prescribed by a **physician** for the treatment of certain diseases which include, but are not limited to:

- inherited diseases of amino acid or organic acid metabolism;
- Crohn's disease;

- gastroesophageal reflux with failure to thrive;
- disorders of gastrointestinal motility;
- multiple, severe food allergies.

Transplant Services *(GR-9N-11-160-02 NY)*

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

Network of Transplant Specialist Facilities

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

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

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

The plan covers:

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

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

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered in connection with the transplant event.

For purposes of this section, the following will be considered to be one transplant occurrence:

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

The following will be considered to be *more than one* transplant occurrence:

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

Limitations

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

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.
- Services that are covered under any other part of this plan.
- Services and supplies furnished to a donor when the recipient is not a covered person.
- Home infusion therapy after the transplant occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing **illness**.
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing **illness**.

Important Reminders

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

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable. Transplant expenses are subject to a separate payment limit. Refer to the *Schedule of Benefits*.

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

(The financial requirements and treatment limitations applicable to the mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied substantially all medical and surgical benefits covered herein.)

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

Mental Disorders

Covered expenses include charges made for the treatment of **mental disorders** and of Children with Serious Emotional Disturbances by **behavioral health providers**.

Treatment of **mental disorders** means: the **medically necessary** care rendered by an eligible practitioner or approved facility and which, in the opinion of Aetna, is directed predominantly at treatable behavioral manifestations of a condition that Aetna determines (a) is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and (b) substantially or materially impairs a person's ability to function in one or more life activities; and (c) has been classified as a **mental disorder** in the current American Psychiatric Diagnostic and Statistical Manual of Mental Disorders.

Children with Serious Emotional Disturbances means: Persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

- Serious suicidal symptoms or other life-threatening self-destructive behaviors;
- Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
- Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or
- Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate,** and other services and supplies provided during your **stay** in a **hospital** or **psychiatric hospital** (as defined in the mental hygiene law) or non-hospital **residential treatment facility** appropriately licensed by the Department of Health or equivalent. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting. This Plan also covers partial hospitalization services. One inpatient hospitalization day may be exchanged for two partial hospitalization visits.

Outpatient Treatment

Covered expenses include charges for treatment received in a facility issued an operating certificate by the Commissioner of Mental Health, a facility operated by the Office of Mental Health, a licensed psychiatrist, psychologist or clinical social worker, or a professional corporation or university faculty practice corporation. Also covered are expenses for crisis intervention services (these are services rendered in connection with an unforeseen clinical condition which requires prompt action, since without such action the person may be at risk of injuring him or herself or others; or the person is at risk of substantially deterioration).

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

Substance Use *(GR-9N 11-172 01 NY)*

Covered expenses include charges made for the treatment of **substance use** by **behavioral health providers.**

Inpatient Treatment

This Plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **hospital** or **residential treatment facility**, appropriately certified by the Office of Alcoholism and Substance Abuse services, or its equivalent in states other than New York.

Coverage includes detoxification and rehabilitation services.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for **substance use** while not confined as a full-time inpatient in a **hospital** or **residential treatment facility**.

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

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) *(GR-9N 11-180-01)*

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when ***not*** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

(a) Natural teeth damaged, lost, or removed; or
(b) Other body tissues of the mouth fractured or cut

due to **injury**.

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

The treatment must be completed in the Calendar Year of the **accident** or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Medical Plan Exclusions *(GR 9 N S 28-015 01 NY)*

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet-Certificate.

Important Note:
You have medical and prescription drug insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific prescription drug coverage. Those additional exclusions are listed separately under the *What The Plan Covers* section for each of these benefits.

Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge,** or an **out-of-network provider** in excess of the **recognized charge**.

- Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, the shape or appearance of the body whether or not for psychological or emotional reasons, unless **medically necessary**. But this exclusion will not apply to (i) *Reconstructive Services and Specialized Care Services* under *What the Plan Covers* section; (ii) removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogentic cysts; or covered dental services or supplies to treat congenital defects or anomalies (including cleft lip or cleft palate) of covered dependent children.

Custodial Care

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

Services that are not covered under this Booklet-Certificate.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

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

Your Pharmacy Benefit *(GR-9N-S-12-005-02)*

How the Pharmacy Plan Works

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

- Definitions you need to know;
- How to access **network pharmacies** and procedures you need to follow;
- What **prescription drug** expenses are covered and what limits may apply;
- What **prescription drug** expenses are not covered by the plan;
- How you share the cost of your covered **prescription drug** expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

A few important notes to consider before moving forward:

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

(GR-9N 12-005 01 NY)
Notice
The plan does not cover all **prescription drugs**, medications and supplies. Refer to the Limitations section of this coverage and *Exclusions* section of your Booklet-Certificate.

- **Covered expenses** are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage and in your Schedule of Benefits.

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

You will find the terms below used throughout this Booklet-Certificate. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary*.

Brand-Named Prescription Drug is a **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by **Aetna**.

Generic Prescription Drug is a **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by **Aetna**.

Network pharmacy is a description of a **retail, mail order or specialty pharmacy** that has entered into a contractual agreement with **Aetna**, an affiliate, or a third party vendor, for the provision of **covered services** to you and your covered dependents. The appropriate **pharmacy** type may also be substituted for the word **pharmacy**. (E.g. **network retail pharmacy, network mail order pharmacy or specialty pharmacy network**).

Non-Preferred Drug (Non-Formulary) is a **brand-named prescription drug** or **generic prescription drug** that does not appear on the **preferred drug guide**.

Out-of-network pharmacy is a description of a **pharmacy** that has not contracted with **Aetna**, an affiliate, or a third party vendor, and does not participate in the pharmacy network.

Preferred Drug (Formulary) is a **brand-named prescription drug** or **generic prescription drug** that appears on the **preferred drug guide**.

Preferred Drug Guide is a listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand-named prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna**. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.aetna.com/formulary.

Prescription Drug is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

Provider is any recognized health care professional, pharmacy or facility providing services with the scope of their license.

Self-injectable Drug(s). Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

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

Accessing Pharmacies and Benefits *(GR-9N-S-12-015-01-NY)*

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. Aetna has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network** and **out-of-network benefits**. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty pharmacies.

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

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

Accessing Network Pharmacies and Benefits *(GR-9N-12-015-02)*

You may select a network **pharmacy** from the **Aetna** Network Pharmacy Directory or by logging on to **Aetna's** website at www.aetna.com. You can search **Aetna**'s online directory, DocFind, for names and locations of network **pharmacies**. If you cannot locate a network **pharmacy** in your area call Member Services.

You must present your ID card to the network **pharmacy** every time you get a **prescription** filled to be eligible for network **benefits**. The network **pharmacy** will calculate your claim online. You will pay any deductible, copayment or coinsurance directly to the network **pharmacy**.

You do not have to complete or submit claim forms. The network **pharmacy** will take care of claim submission.

Emergency Prescriptions *(GR-9N-S-12-015-01-NY)*

When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain network benefits by filling your **prescription** at any **network retail pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan's cost sharing amount. If you access an **out-of-network pharmacy** you will pay the full cost of the prescription and will need to file a claim for reimbursement, you will be reimbursed for your **covered expenses** up to the cost of the prescription less any applicable cost sharing required by you.

Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the provider contract.

Cost Sharing for Network Benefits

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

- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The **copayment** is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.

- After you pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** is based on the **negotiated charge**. Your **coinsurance** amount is determined by applying the applicable **coinsurance** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

When You Use an Out-of-Network Pharmacy *(GR-9N-S-12-020-01-NY) (GR-9N 13-005 01 NY)*

You can directly access an **out-of-network pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-network **pharmacy**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

Cost Sharing for Out-of-Network Benefits *(GR-9N-S-12-020-01-NY)*

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

- You will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** share is based on the **recognized charge**. If the **out-of-network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

Pharmacy Benefit *(GR-9N 13-005 01 NY)*

What the Plan Covers

The plan covers charges for outpatient **prescription drugs** for the treatment of an **illness** or injury, subject to the Limitations section of this coverage and the Exclusions section of the Booklet-Certificate. Prescriptions must be written by a **prescriber** licensed to prescribe federal legend prescription drugs.

Your prescription drug benefit coverage is based on **Aetna's preferred drug guide**. The **preferred drug guide** includes both **brand-name prescription drugs** and **generic prescription drugs**. Your out-of-pocket expenses may be higher if your **physician** prescribes a covered **prescription drug** not appearing on the **preferred drug guide**.

Generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. You may minimize your out-of-pocket expenses by selecting a **generic prescription drug** when available.

Coverage of **prescription drugs** will be subject to, **step therapy** or other **Aetna** requirements or limitations. **Prescription drugs** covered by this plan are subject to drug utilization review by **Aetna** and/or your **provider** and/or **your network pharmacy**.

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

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a network retail **pharmacy**. Each **prescription** is limited to a maximum 30 day supply when filled at a network retail **pharmacy**. **Prescriptions** for more than a 30 day supply are not eligible for coverage when dispensed by a network retail **pharmacy**.

All prescriptions and refills over a 30 day supply must be filled at a **mail order pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a network **mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a network **mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network **mail order pharmacy**.

Self-Injectable Drugs - Specialty Pharmacy Network Benefits

Self-injectable drugs are covered at the network level of benefits only when dispensed through a **network retail pharmacy** or **Aetna's specialty pharmacy network**. Refer to the **preferred drug guide** for a list of **self-injectable drugs**. You may refer to **Aetna's** website, www.aetna.com to review the list anytime. The list may be updated from time to time.

The initial prescription for a **self-injectable drug** must be filled at a **network retail pharmacy** or at **Aetna's specialty pharmacy network**.

You are required to obtain **self-injectable drugs** at **Aetna's specialty pharmacy network** for all prescription drug refills after the initial fill.

Each **prescription** is limited to a maximum 30 day supply when filled at **Aetna's specialty pharmacy network**.

Other Covered Expenses *(GR-9N 13-005 01 NY)*

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

Off-Label Use *(GR-9N 13-005 01 NY)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may be subject to **step-therapy** or other **Aetna** requirements or limitations.

Diabetic Supplies *(GR-9N 13-005 01 NY)*

The following diabetic supplies upon prescription by a **physician**:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.

- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Oral and Self-Injectable Infertility Drugs

The following **prescription drugs** used for the purpose of treating infertility including, but not limited to:

- Urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

Lifestyle/Performance Drugs

Coverage includes:

- Sildenafil Citrate, phentolamine, apomorphine and alprostadil in oral, and topical (which includes, but is not limited to gels, creams, ointments and patches) forms; or any other form, internally or externally, are covered; regardless of **medical necessity**. Coverage includes: any prescription drug in oral or topical form, that is in a similar or identical class; has a similar or identical mode of action; or exhibits similar, or identical outcomes.
- Coverage is limited to 4 pills, or other form; determined cumulatively among all forms for unit amounts; determined by **Aetna** to be similar in cost to: oral forms, per 30 day supply.

Step-Therapy

With **step-therapy**:

- 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 covered.
- No benefit will be payable for a **step therapy** drug unless the corresponding prerequisite therapy drug 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 procedures described below.

Lists of the **step-therapy** drugs and prerequisite drugs are included in the **Aetna preferred drug guide** available upon request or online at www.aetna.com/formulary. The list of step therapy drugs are subject to change by **Aetna**.

Medical Exceptions:

Your **prescriber** may seek a medical exception to obtain coverage for drugs for which coverage is denied through **Step Therapy**. The **prescriber** must submit such exception requests to Aetna. Coverage granted as a result of a medical exception shall be based on an individual, case by case **medical necessity** determination and coverage will not apply or extend to other covered persons.

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

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

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

The number of **copayments/deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

Pharmacy Benefit Exclusions *(GR-9N S-28-020-01 NY)*

Not every health care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet-Certificate . In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

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

Any drugs or medications, services and supplies that are not **medically necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

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

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

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

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

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

Durable medical equipment, monitors and other equipment.

Experimental or investigational drugs or devices, except as described in the *What the Plan Covers* section.

This exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the illness.

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion will not apply to expenses incurred for enteral formulas for home use and modified solid food products that are low in protein or which contain protein, which are prescribed by a **physician** for the treatment of certain diseases which include, but are not limited to: (a) inherited diseases of amino acid or organic acid metabolism; (b) Crohn's disease; (c) gastroesophageal reflux with failure to thrive; (d) disorders of gastrointestinal motility; (e) multiple, severe food allergies.

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

Immunization or immunological agents.

Implantable drugs and associated devices.

Injectables:

- Any charges for the administration or injection of **prescription drug**s or injectable insulin and other injectable drugs covered by **Aetna**;
- Needles and syringes, except for diabetic needles and syringes;
- Unless **medically necessary**, injectable drugs if an alternative oral drug is available;

Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

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

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

Prophylactic drugs for travel.

Refills in excess of the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or evidence as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescription**s.

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

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

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

When Coverage Ends *(GR-9N-30-005-02 NY) (GR-9N 30-005-HRPA-NY)*

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;

- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, **Aetna** may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not actively at work due to **illness or injury**, your coverage may continue, until stopped by your employer, but not beyond 3 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

Your Proof of Prior Medical Coverage *(GR-9N 30-010 01-NY)*

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

When Coverage Ends for Dependents *(GR-9N-30-015-02) (GR-9N 030-030 01)*

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make the required contribution toward the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees (other than exhaustion of your overall maximum lifetime benefit, if included);
- Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent; or
- Your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.

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

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

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after your dependent reaches any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage *(GR-9N 31-010 03) (GR-9N 31-015 02-NY)*

Continuing Health Care Benefits *(GR-9N 31-015 01-NY) (GR-9N DEP30)*

Continuation of Coverage

If all or a portion of your health expense coverage would terminate because you terminate employment or membership in the eligible classes, coverage (other than Dental Expense Coverage) may be continued for you and your eligible dependents. Coverage will not be continued for any person who is eligible for a like continuation under federal law.

Within 60 days of the later of:

- The date coverage would otherwise terminate; and
- The date you are sent notice by first class mail by your employer of the right to continue;

You must elect the continuation in writing and pay the first contribution. The contribution required may be up to 102% of the cost to this plan. Premium payments must be continued.

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

- The end of an 18 month period which starts on the date coverage would otherwise terminate.
- The end of a 29 month period which starts on the date your coverage would otherwise terminate; but only if, prior to the end of the above 18 months period, you provide notice to your employer that you have been determined to be disabled under Title II or XVI of the Social Security Act on the date your coverage would have otherwise terminated, except for this continuation. If you are no longer determined to be so disabled, you must notify your employer within 30 days of such determination. In that case, coverage will cease at the start of the month that begins more than 31 days after the date of the final determination that you are no longer so disabled.
- The date you become eligible for like group coverage, including coverage for any preexisting condition.
- The end of the period for which any required contributions have been made.
- Discontinuance of the coverage involved as to employees of the eligible class of which you were a member.
- The date you become enrolled in benefits under Medicare.

Coverage for a dependent may not be continued beyond the date it would otherwise terminate.

If any coverage being continued ceases, you may apply for a conversion policy. See *Converting to an Individual Health Policy*.

Continuing Coverage for Dependent Students on Medical Leave of Absence *(GR-9N 31-015 01-NY)*

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious **illness** or **injury**, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;

- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this **plan** and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your **employer** as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. **Aetna** may require a written certification from the treating **physician** which states that the child is suffering from a serious **illness** or **injury** and that the resulting leave of absence (or change in full-time student status) is **medically necessary**.

Important Note
If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

Handicapped Dependent Children *(GR-9N 31-015 01-NY)*

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

Your child is fully handicapped if:

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

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

Coverage will cease on the first to occur of:

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

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

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

Coverage for Health Benefits

If your health benefits end while you are totally disabled, your health expenses will be extended as described below, but, with respect to medical benefits, only as to expenses incurred in connection with the **injury** or **illness** that caused the total disability. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

"Totally disabled" means that because of an **injury** or **illness**:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage *(GR-9N 31-020 01)*

(GR-9N 31-020 01)
Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

Prescription Drug Benefits: Coverage will be available while you are totally disabled for up to 12 months.

When Extended Health Coverage Ends
Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

Important Note
If the Extension of Benefits provision outlined in this section applies to you or your covered dependents, see the *Converting to an Individual Health Insurance Policy* section for important information.

COBRA Continuation of Coverage *(GR-9N 31-025 NY)*

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a "qualifying event" that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA
When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer's notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

Who Qualifies for COBRA
You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
Your marriage is annulled, you divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events.

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Premium Payments for Continuation Coverage

Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

Important Note
For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

Conversion from a Group to an Individual Plan

You may be eligible to apply for an individual health plan without providing proof of good health:

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

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

Converting to an Individual Medical Insurance Policy

Eligibility

You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical plan because:

- You terminate your employment;
- You are no longer in an eligible class;
- Your dependent no longer qualifies as an eligible dependent;
- Any continuation coverage required under federal or state law has ended; or
- You retire and there is no medical coverage available.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

Features of the Conversion Policy

The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent's states of residence; and
- Offered by **Aetna** when you or your dependents apply under your employer's conversion plan.

However, coverage will not be the same as your group plan coverage. Generally, the coverage level may be less, and there is an applicable overall lifetime maximum benefit.

If the plan does not include major medical benefits, coverage may be elected under one of the following plans:

- Plan I: Hospital room and board expense benefits of $130 per day. The maximum duration is 30 days. Miscellaneous hospital expense benefits to a maximum of $1,300. Surgical operation expense benefits according to a $1,400 maximum benefits schedule.
- Plan II: Hospital room and board expense benefits of $230 per day. The maximum duration is 30 days. Miscellaneous hospital expense benefits to a maximum of $2,300. Surgical operation expense benefits according to a $2,400 maximum benefits schedule.
- Plan III: Hospital room and board expense benefits of $330 per day. The maximum duration is 70 days. Miscellaneous hospital expense benefits to a maximum of $3,300. Surgical operation expense benefits according to a $3,500 maximum benefits schedule.

If the plan includes only major medical benefits, coverage may be elected under the following plan only:

- Plan IV: Major medical expense benefits providing: (a) a $330 per day hospital room and board benefit; (b) surgical expense benefits according to a $4,500 maximum benefits schedule; (c) a $200,000 maximum benefit for all sicknesses and injuries; (d) a deductible of $1,000; (e) an 80% benefit percentage, with a coinsurance limit of $2,000; and (f) an annual restoration benefit of $5,000.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy;
- Require a statement that **Aetna** may ask for data about your coverage under any other plan. This may be asked for on any premium due date for the individual policy. If you do not give the data, expenses covered under the individual policy may be reduced by expenses which are covered or provided under those plans.

Limitations

You or your dependents do not have a right to convert if:

- You or your dependents are eligible for Medicare. Covered dependents not eligible for Medicare may apply for individual coverage even if you are eligible for Medicare.
- Coverage under the plan has been in effect for less than three months.

- A lifetime maximum benefit under this plan has been reached. For example:
  - If a covered dependent reaches the group plan's lifetime maximum benefit, the covered dependent will not have the right to convert. If you or your dependents have remaining benefits, you are eligible to convert.
  - If you have reached your lifetime maximum, you will not be able to convert. However, if a dependent has a remaining benefit, he or she is eligible to convert.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You apply for individual coverage in a jurisdiction where **Aetna** cannot issue or deliver an individual conversion policy.
- You or your covered dependents are eligible for, or have benefits available under, another plan that, in addition to the converted policy, would either match benefits or result in over insurance. Examples include:
  - Any other hospital or surgical expense insurance policy;
  - Any hospital service or medical expense indemnity corporation subscriber contract;
  - Any other group contract; or
  - Any statute, welfare plan or program.

Electing an Individual Conversion Policy

You or your covered dependents have to apply for the individual policy within 45 days after your coverage ends. The 45 days start on the date group coverage ceases. The application period will be extended for 45 days from the date your employer gives you written notice of the conversion privilege, as required by law, but not beyond 90 days from the date group coverage ceases.

If coverage ends because of retirement, the 45 day application period begins on the date coverage under the group plan actually ends. This applies even if you or your dependents are eligible for benefits based on a disability continuation provision because you or they are totally disabled.

To apply for an individual medical insurance policy:

- Get a copy of the "Notice of Conversion Privilege and Request" form from your employer.
- Complete and send the form to **Aetna** at the specified address.

Your Premiums and Payments

Your first premium payment will be due at the time you submit the conversion application to **Aetna**.

The amount of the premium will be **Aetna's** normal rate for the policy that is approved for issuance in your or your dependent's state of residence.

When an Individual Policy Becomes Effective

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once **Aetna** receives and processes your completed application and premium payment.

Coordination of Benefits - What Happens When There is More Than One Health Plan

When Coordination of Benefits Applies

Getting Started - Important Terms

Which Plan Pays First

How Coordination of Benefits Works

When Coordination of Benefits Applies

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

Getting Started - Important Terms

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

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

- 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 room is medically necessary in terms of generally accepted medical practices, or one of the Plans routinely provides coverage of hospital private rooms) is not an allowable expense.

If a person is covered by one Plan that computes its benefit payments on the basis of recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

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

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

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

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

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

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

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

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

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

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

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

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

To find out whether the regular benefits under this plan will be reduced, the order in which the various plans will pay benefits must first be figured. This will be done as follows:

- A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
- A plan which covers a person as other than a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent.

    1. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers a person as a dependent of a person whose birthday comes later in the year; however:
        (a) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
        (b) if the other plan does not have the rules described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefit, the rule in the other plan will determine the order of benefits.

2. In the case of a dependent child whose parents are divorces or separated:
   (a) If there is a court decree which makes one parent financially responsible for the health care expenses with respect to the child and the entity obligated to pay or provide the benefits of that parent has actual knowledge of those terms, the benefits of that plan which covers the child as a dependent of such parent shall be determined before the benefits of any other plan which covers the child as a dependent child.
   (b) If there is no such court decree, the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the **custodial parent**;
      - The plan of the non**custodial parent**; and then
3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
4. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.
5. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works

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

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

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

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

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

When You Have Medicare Coverage

(GR-9N 33-020-01)

Which Plan Pays First

How Coordination with Medicare Works

What is Not Covered

This section explains how the benefits under **This Plan** interact with benefits available under **Medicare**.

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

You are eligible for **Medicare** if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under it because you:
  1. Refused it;
  2. Dropped it; or
  3. Failed to make a proper request for it.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the primary payor, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the secondary payor, and pays benefits after **Medicare**.

Which Plan Pays First

The plan is the primary payor when your coverage for the **plan**'s benefits is based on current employment with your employer. The **plan** will act as the primary payor for the **Medicare** beneficiary who is eligible for **Medicare**:

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

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

The **plan** pays benefits first when it is the primary payor. You may then submit your claim to **Medicare** for consideration.

When Medicare is Primary

Your health care expense must be considered for payment by **Medicare** first. You may then submit the expense to **Aetna** for consideration.

Aetna will calculate the benefits the **plan** would pay in the absence of **Medicare**:

- If the result is more than the benefit paid by **Medicare**, the **plan** will pay the difference, up to 100% of plan expenses. Plan expenses are any **medically necessary** health expenses which are covered, in whole or in part, under the plan.
- If the result is less than the benefit paid by **Medicare**, the **plan** will not pay a benefit, except as required by law.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **plan** in the order received by **Aetna**. **Aetna** will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information *(GR-9N-S-33-025-01)*

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **This Plan** and other **plans**. **Aetna** has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

General Provisions

(GR-9N-32-005-02-NY)

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Legal Action

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

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

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of the plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna**'s Notice of Information Practices by calling **Aetna**'s toll-free Member Service telephone.

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *group policy*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

Assignments

Coverage may be assigned only with the written consent of **Aetna**. To the extent allowed by law, **Aetna** will not accept an assignment to an **out-of-network provider**, including but not limited to, an assignment of:

- The benefits due under this group insurance policy;
- The right to receive payments due under this group insurance policy; or
- Any claim you make for damages resulting from a breach or alleged breach, of the terms of this group insurance policy.

Misstatements

If any fact as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by you, an eligible employee or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Subrogation and Right of Reimbursement

As used herein, the term "**Third Party**", means any party that is, or may be, or is claimed to be responsible for **illness** or **injuries** to you. Such **illness** or **injuries** are referred to as "**Third Party Injuries**." "**Third Party**" includes any party responsible for payment of expenses associated with the care of treatment of **Third Party Injuries**.

If this plan pays benefits under this Booklet-Certificate to you for expenses incurred due to **Third Party Injuries**, then **Aetna** retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are (a) associated with the **Third Party Injuries;** and (b) specifically identified or allocated as payments previously made by **Aetna** for such injuries in any recovery, settlement, judgment or compensation agreement. **Aetna**'s rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a **Third Party** or any insurance company on behalf of the **Third Party**;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;

- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for **injuries** resulting from an accident or alleged negligence.

By accepting benefits under this plan, you specifically acknowledge **Aetna**'s right of subrogation. In the event you suffer injuries for which a **Third Party** is responsible (such as someone injuring you in an accident), and **Aetna** pays benefits as a result of those injuries, **Aetna** will be subrogated and succeed to the right of recovery against such **Third Party** to the extent of the benefits **Aetna** has paid. This means that **Aetna** has the right, independently of you, to proceed against the **Third Party** responsible for your injuries to recover the benefits **Aetna** has paid.

By accepting benefits under this plan, you also specifically acknowledge **Aetna**'s right of reimbursement. This right of reimbursement attaches when this plan has paid health care benefits for expenses incurred due to **Third Party Injuries** and you or your representative has recovered any amounts from a **Third Party**. By providing any benefit under this Booklet-Certificate, **Aetna** is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan, but only to the extent such benefits are identified or allocated as payments previously made by **Aetna** for such injuries in any recovery, settlement, judgment or compensation agreement. **Aetna**'s right of reimbursement is cumulative with and not exclusive of **Aetna**'s subrogation right and **Aetna** may choose to exercise either or both rights of recovery.

By accepting benefits under this plan, you or your representatives further agree to:

- Notify **Aetna** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to **Third Party Injuries** sustained by you;
- Cooperate with **Aetna** and do whatever is necessary to secure **Aetna**'s rights of subrogation and reimbursement under this Booklet-Certificate;
- Give **Aetna** a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with **Third Party Injuries** provided by this plan (but only to the extent such benefits are identified or allocated as payments previously made by **Aetna** for such injuries in any recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due **Aetna** as reimbursement for the full cost of all benefits associated with **Third Party Injuries** paid by this plan (but only to the extent such benefits are identified or allocated as payments previously made by **Aetna** for such injuries in any recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **Aetna** in writing; and
- Do nothing to prejudice **Aetna**'s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of **Third Party Injuries**.

Aetna may recover full cost of all benefits paid by this plan under this Booklet-Certificate without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **Aetna**'s recovery, and **Aetna** is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any **Third Party** without the prior express written consent of **Aetna**.

Worker's Compensation

If benefits are paid by **Aetna** and **Aetna** determines you received Worker's Compensation benefits for the same incident, **Aetna** has the right to recover as described under the *Subrogation and Right of Reimbursement* provision. **Aetna** will exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily **injury** or **illness** was sustained in the course of or resulted from your employment;
- The amount of Worker's Compensation due to medical or health care is not agreed upon or defined by you or the Worker's Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this policy, you will notify **Aetna** of any Worker's Compensation claim you make, and that you agree to reimburse **Aetna** as described above.

If benefits are paid under this policy and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna** has a right to recover from you or your covered dependent an amount equal to the amount **Aetna** paid.

Recovery of Overpayments *(GR-9N-S-30-015-01)*

Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

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

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

Reporting of Claims *(GR-9N-S-30-015-01)*

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

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible.

Payment of Benefits *(GR-9N 32-025 02-NY)*

Benefits will be paid as soon as the necessary proof to support the claim is received, but not later than 45 days after receipt of such proof. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

Any unpaid balance will be paid within 30 days of receipt by **Aetna** of the due written proof.

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

When a **PCP** provides care for you or a covered dependent, or care is provided by **a network provider** (**network services or supplies**), the **network provider** will take care of filing claims. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

Records of Expenses *(GR-9N-32-030-02)*

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

Very important are:

- Names of **physicians**, **dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Effect of Benefits Under Other Plans *(GR-9N 32-035-01)*

Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care), if any, on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

Any extensions of benefits under this plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan providing medical coverage. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- The end of a 90 day period; and
- The date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Prior Coverage - Transferred Business *(GR-9N-32-040-02 NY)*

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

health coverage under this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided under the section, *Continuing Coverage for Dependent Students on Medical Leave of Absence.*

Glossary

(GR-9N 34-005 01-NY)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

A *(GR-9N 34-010 01-NY) (GR-9N 34-005 02)*

Accident *(GR-9N 34-005 01-NY)*

This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Policy. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Ambulance

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Average Wholesale Price (AWP)

The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

B *(GR-9N 34-010 01-NY) (GR-9N 34-005 01-NY)*

Behavioral Health Provider

A licensed facility, organization or **other health care** provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, **mental disorders** acting within the scope of the applicable license. This includes:

- **Hospitals**;
- Psychiatric **hospitals**;
- **Residential treatment facilities**;
- **Psychiatric physicians**;
- Psychologists;
- Social workers;
- Psychiatric nurses;
- Addictionologists; and
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

Birthing Center

A freestanding facility that meets ***all*** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.

- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Brand-Name Prescription Drug

A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

C *(GR-9N 34-015 02)*

Coinsurance

Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as "plan **coinsurance**" and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

Coinsurance Limit

- **Coinsurance limit** is the maximum out-of-pocket amount you are responsible to pay for **coinsurance** for **covered expenses** during your calendar year. Once you satisfy the **coinsurance limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the calendar year You have separate **coinsurance limits** for network and out-of-network benefits.

Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits.*

Cosmetic

Services or supplies that alter, improve or enhance appearance.

Covered Expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

Creditable Coverage

A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service or tribal organization;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care

This means services and supplies that are primarily intended to help you meet personal needs, such as transferring, eating, dressing, bathing, toileting and such other related activities. This includes board and room and other institutional care. You do not have to be disabled. Such services and supplies are **custodial care** without regard to:

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

D *(GR-9N 34-020 01) (GR-9N 34-095 01-NY)*

Deductible

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

Deductible Carryover

This allows you to apply any **covered expense** incurred during the last 3 months of a calendar year that is applied toward this year's **deductible** to also apply toward the following year's **deductible**.

Dentist

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

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory

A listing of all **network providers** serving the class of employees to which you belong. The policyholder will give you a copy of this **directory**. **Network provider** information is available through **Aetna's** online provider **directory**, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this **directory**.

Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

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

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E *(GR-9N 34-025 01 NY)*

Emergency Medical Condition

A recent and severe medical or behavioral condition, the onset of which is sudden, manifests itself by symptoms of sufficient 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, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- In the case of a behavioral condition, placing the health of such person, or others', in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- Serious disfigurement of such person; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational

A drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is **experimental or investigational**, or for research purposes.

G *(GR-9N 34-035 01)*

Generic Prescription Drug

A **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by **Aetna** or an affiliate.

H *(GR-9N 34-040 02)*

Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services;**
  - Medical social services; and
  - Psychological and dietary counseling.

- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility

A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**
- Has a full-time administrator.

Hospital

This means a short-term, acute, general hospital which:

- Is primarily engaged in providing, by or under the continuous supervision of **physicians**, to inpatients, diagnostic services and therapeutic services for diagnostic, treatment and care of injured and sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a **physician** or dentist;
- Provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861k of U.S. Public Law 89-97 (42 USCA 1395x(k));

- Is duly licensed by the agency responsible for licensing such hospitals;
- Makes charges; and
- Is not, other than incidentally, a place for rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

Hospitalization
A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

I *(GR-9N 34-045 02)*

Illness *(GR-9N 34-045 02)*
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- *For a* woman *who is 21 or more but less than 35 years of age*: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- *For a* woman *who is 35 years of age or older, but less than 45*: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

Institute of Excellence (IOE)
A **hospital** or other facility that has contracted with **Aetna** to furnish services or supplies to an **IOE** patient in connection with specific transplants at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants for which it has signed a contract.

J *(GR-9N 34-050 01)*

Jaw Joint Disorder *(GR-9N 34-050 01)*
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any 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 *(GR-9N 34-055 01)*

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 Booklet-Certificate.

Lifetime Maximum

This is the most the plan will pay for **covered expenses** incurred by any one covered person during their lifetime.

L.P.N.

A licensed practical or vocational nurse.

M *(GR-9N-34-065-04 NY)*

Mail Order Pharmacy

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

Maintenance Care

Care made up of services and supplies that:

- Are furnished mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

Medically Necessary or Medical Necessity

Health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms, and that provision of the service, supply or **prescription drug** is:

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

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

Mental Disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker. A **mental disorder** includes; but is not limited to:

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

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

Mental Disorder

The following conditions are considered a **Mental Disorder** under this plan:

Biologically-based Mental Illnesses - defined as:

- Schizophrenia/psychotic disorders
- Major depression
- Bipolar disorder
- Delusional disorders
- Panic disorder
- Obsessive compulsive disorders
- Bulimia
- Anorexia

Non-Biologically-based Mental Illnesses.

N *(GR-9N 34-070 02)*

Negotiated Charge

As to health expense coverage, other than Prescription Drug Expense Coverage:

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

As to Prescription Drug Expense Coverage:
The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Advanced Reproductive Technology (ART) Specialist

A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology** (**ART**) services.

Network Provider

A health care provider or **pharmacy** who has contracted to furnish services or supplies for **this plan**; but only if the provider is, with **Aetna**'s consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)
Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **PCP**.

Non-Occupational Illness
A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury
A **non-occupational injury** is an accidental bodily **injury** that does not:

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

Non-Preferred Drug (Non-Formulary)
A **prescription drug** that is not listed in the **preferred drug guide**. This includes **prescription drugs** on the **preferred drug guide exclusions list** that are approved by medical exception.

Non-Specialist
A **physician** who is not a **specialist**.

Non-Urgent Admission
An inpatient admission that is not an **emergency admission** or an **urgent admission**.

O *(GR-9N-34-065 01-NY) (GR-9N 34-075 01)*

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

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

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

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

Orthodontic Treatment *(GR-9N 34-075 01)*
This is any:

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

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

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

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

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

Out-of-Network Service(s) and Supply(ies) *(GR-9N 34-075 01)*
Health care service or supply that is:

- Furnished by an **out-of network provider**; or
- Not furnished or arranged by your **PCP**.

Out-of-Network Provider
A health care provider or **pharmacy** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

P *(GR-9N-34-080-05 NY)*

Pharmacy
An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;

- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Preferred Drug Guide

A listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Preferred Drug Guide Exclusions List

A list of **prescription drugs** in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna**.

Prescriber

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

Prescription

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

Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Physician (PCP)

This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on **Aetna**'s records as the person's **PCP**.

Psychiatric Hospital

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

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.

- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or **mental disorders**.

R *(GR-9N-34-065-04 NY) (GR-9N 34-095 01-NY)*

Recognized Charge

Only that part of a charge which is less than or equal to the **recognized charge** is a **covered benefit**. The **recognized 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, billed or coded; or
  a) For non-facility charges: **Aetna** uses the provider charge data from the Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months.
  b) For facility charges: **Aetna** uses the charge **Aetna** determines to be the usual charge level made for it in the geographic area where it is furnished

For **prescription drugs**: 110% of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current **average wholesale price** of a **prescription drug** listed in the Medi-Span weekly price updates (or any other similar publication chosen by **Aetna** on the day that a **pharmacy** claim is submitted for adjudication).

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

- Unusual; or
- Not often provided in the geographic area; or
- Provided by only a small number of **providers** in the geographic 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 **recognized charge** in other geographic 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 **recognized charge** is the rate established in such agreement.

As used above, the term "geographic area" means a Prevailing HealthCare Charges System (PHCS) expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are utilized.

Rehabilitation Facility

A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services

The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

Residential Treatment Facility (Mental Disorders)

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

- Has, on-site licensed **Behavioral Health Provider** 24 hours per day.
- Provides a comprehensive patient assessment.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions.
- Has the ability to involve family/support systems in therapy.
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Is managed by a licensed **Behavioral Health Provider** who functions under the direction and supervision of a **psychiatric physician**.
- 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.
- Provides active discharge planning initiated upon admission to the program.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.

Residential Treatment Facility (Substance Abuse)

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

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **Physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.

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

R.N.
A registered nurse.

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

S *(GR-9N 34-095-02) (GR-9N 34-090 01-NY)*

Self-injectable Drug(s)
Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

Semi-Private Room Rate
The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area
This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.

Skilled Nursing Facility
An institution that meets all of the following requirements:

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

- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of **Hospitals** of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.

Skilled Nursing Services

Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care

Health care services or supplies that require the services of a **specialist**.

Specialty Pharmacy Network

A network of pharmacies designated to fill **self-injectable drug prescriptions**.

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Step Therapy

Procedures under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Substance Abuse

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

Surgery Center

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

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**; and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- **Physician**s who do not own or direct the facility.
- Keeps a medical record on each patient.

T *(GR-9N 34-095 01-NY) (GR-9N 34-100-02)*

Terminally Ill (Hospice Care)

Terminally ill means a medical prognosis of 6 months or less to live.

Therapeutic Drug Class

A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

U *(GR-9N-S-34-105-01)*

Urgent Admission

A **hospital** admission by a **physician** due to:

- The onset of or change in a **illness**; or
- The diagnosis of a **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - 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 network **urgent care provider**.
- It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

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

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

Aetna Life Insurance Company

Hartford, Connecticut 06156

PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT

This Amendment changes provisions in, or adds provisions to, your Certificate, including any affected riders, endorsements or other amendments thereto, (hereinafter collectively "Group Plan") issued by **Aetna** as required by the federal Patient Protection and Affordable Care Act. Except as otherwise provided in this Amendment, the provisions herein apply to all persons covered under the "Group Plan." All of the terms, conditions, and limitations of the Certificate to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment. This Amendment shall take effect on your Group Plan's renewal date on or after September 23, 2010.

1. **Emergency Services.**

   A. **Emergency Condition Defined.** The definition of Emergency Medical Condition in your Certificate is hereby deleted in its entirety and replaced with the following:

      Emergency Condition. A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

      (1) Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

      (2) Serious impairment to such person's bodily functions;

      (3) Serious dysfunction of any bodily organ or part of such person; or

      (4) Serious disfigurement of such person.

   B. **Emergency Services Defined.** The following definition is hereby added to your Certificate:

      Emergency Services. A medical screening examination that is within the capability of the emergency department of a **hospital**, including ancillary services routinely available to the emergency department to evaluate an **Emergency Condition**; and within the capabilities of the staff and facilities available at the **hospital**, such further medical examination and treatment as are required to stabilize the patient.

   C. **Coverage. Emergency Services** are not subject to prior authorization requirements.

   D. **Cost Sharing.** Any Copayment or Coinsurance requirement in the Certificate that applies to **Emergency Services** provided by an **Out-of-Network Provider** that differs from the Copayment or Coinsurance required for **Emergency Services** provided by an **In-Network Provider** is hereby deleted and replaced with the Copayment or Coinsurance requirement, if any, applicable to **Emergency Services** provided by **In-Network Providers**.

   E. **Your Payments.** You are responsible for any applicable Deductible, Copayment, or Coinsurance. We will ensure that you are held-harmless for any charges that exceed the Deductible, Copayment, or Coinsurance.

2. **Preventive Services.** To the extent items and services in the sources referenced below are not already covered benefits for adults and children under the Plan, benefits for the items and services are hereby added to your Certificate:

   A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;

   B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and

   C. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").

   The preventive services referenced above shall be covered in full when received from **In-Network Providers**. The preventive services referenced to above are only covered when provided by **In-Network providers**. Cost sharing (e.g., Copayments, Deductibles, Coinsurance) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

   A list of the preventive services covered under this paragraph is available on our website at www.Aetna.com, or will be mailed to you upon request. You may request the list by calling the customer services number on your identification card.

3. **Access to OB/GYNs.** Any provision in Certificate that limits the number of visits you can make to an **In-Network Provider** who specializes in obstetrics or gynecology without a referral from your Primary Care Physician is hereby deleted in its entirety. You do not need prior authorization from us or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from an **In-Network Provider** who specializes in obstetrics or gynecology. The **In-Network Provider**, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of **In-Network Providers** who specialize in obstetrics or gynecology, contact us at the customer service number on your identification card.

4. **Choice of Primary Care Provider.** Your Plan generally requires the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in our **network** and who is available to accept you or your family members. For children, you may designate a pediatrician as a PCP. For information on how to select a PCP, and for a list of the **In-Network** PCPs, contact us at the customer service number on your identification card.

5. **Annual Limits.** Any annual dollar limit under this Certificate that applies to **Essential Benefits**, whether such annual limit applies only to an **Essential Benefit** or includes **Essential Benefits** and other benefits, is hereby deleted. "**Essential Benefits**" means benefits covered under the Plan in at least the following categories: ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; pediatric services including oral and vision care; and any other services to the extent required in regulations issued pursuant to the Patient Protection and Affordable Care Act.

6. **Pre-Existing Conditions.** Under this Amendment, the provision, if any, in your Certificate that allows us to exclude or otherwise limit coverage for **Pre-Existing Conditions** until a person has been continuously covered under the Plan for a stated period is hereby deleted in its entirety with respect to all persons under the age of 19.

7. **Lifetime Dollar Limits Deleted.** Any lifetime dollar limit under your Certificate is hereby deleted in its entirety.

8. **Dependent Children Covered to Age 26**. If your Plan makes coverage of dependents available, this Amendment applies to coverage of children as follows:

   A. If you selected other than individual coverage, your children who are under the age of 26 may be covered under your Plan. Coverage lasts until the end of the month in which the child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. Children-in-law (spouses of children) and grandchildren are not covered under this Amendment.

      Coverage for your child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attaining age 26 shall not terminate while this Certificate remains in effect and the child remains in such condition, if you submit proof of your child's incapacity within 31 days of your child's attaining age 26.

   B. "Children" include your natural children, a legally adopted child; a step child; and a child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption period. Coverage lasts until the end of the month in which the child turns 26 years of age.

   C. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order is covered. Coverage lasts until the end of the month in which the child turns 26 years of age.

   D. Coverage shall be provided for any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.

   E. Any provisions in your Plan that extends coverage for young adults through age 29 (for example, the provision requiring that the child be unmarried) shall remain in effect for children ages 26 through 29 and are not changed by provisions set forth above in this Paragraph 8 that apply to children under the age of 26.

9. **Rescission.** The provision in the Contract regarding rescissions is hereby deleted and replaced with the following:

   Rescission. We may rescind your coverage if you commit fraud or make an intentional misrepresentation of material fact.

10. **Other Provisions.** All of the terms, conditions, and limitations of the Certificate to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Additional Information Provided by

Sarah Lawrence College

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

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

Name of Plan:
Open Access Managed Choice (Open Access Gatekeeper PPO Plan)

Employer Identification Number:
23-7223216

Plan Number:
509

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

Sarah Lawrence College
1 Mead Way
Bronxville, NY 10708-5999
Telephone Number: (914)395-2365

Agent For Service of Legal Process:

Sarah Lawrence College
1 Mead Way
Bronxville, NY 10708-5999

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

ERISA Rights

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

Receive Information about Your Plan and Benefits

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

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

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

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

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

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

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

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

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

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

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

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

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

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/HealthInsReformforConsume/, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Patient Protection and Affordable Care Act (PPACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of PPACA.

The following is a summary of the requirements under PPACA.

1. For non-grandfathered plans:
   a. Subject to any applicable age, family history and frequency guidelines, the following preventive services, to the extent they are not already, are covered under the plan at the Preferred Care level benefits only. Preventive services will be paid at 100% per visit and without cost-sharing such as payment percentages; copays; deductibles; and dollar maximum benefits:

      - Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;
      - Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and
      - Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").

   b. If the plan requires or recommends that you designate a primary care provider, you may select any participating primary care provider who is available to accept you. In addition, you may select any participating pediatrician as your child's primary care provider, if the provider is available to accept your child.

   c. If your plan requires the referral or authorization from the primary care provider before receiving obstetrical or gynecological care from a participating provider who specializes in obstetrics or gynecological care, this requirement no longer applies. Care includes the ordering of related obstetrical and gynecological items and services that are covered under your plan.

   d. You do not need prior authorization for the treatment of an emergency medical condition, even if the services are provided by a non-participating provider. Care provided by a non-participating provider will be paid at no greater cost to you than if the services were performed by a participating provider. You may receive a bill for the difference between the amount billed by the provider and the amount paid by Aetna. If a non participating provider bills you directly for an amount beyond your cost share for the treatment of an emergency medical condition, you are not responsible for paying that amount. Please send the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over the amount. Make sure your member ID number is on the bill.

   e. You have the right to appeal any action taken by Aetna to deny, reduce or terminate the provision or payment of health care services. When we have done this based on the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service, you have the right to have the decision reviewed by an external review organization.

2. For grandfathered and non-grandfathered plans:
   a. Any overall plan calendar year and lifetime dollar maximums no longer apply.

   b. Any calendar year or annual and lifetime dollar maximum benefit that applies to an "Essential Service" (as required by PPACA and defined by Aetna) for Preferred Care and Non-Preferred Care no longer applies. Essential Services will continue to be subject to any coinsurance; copays; deductibles; other types of maximums (e.g., day and visit maximums); referral and certification rules; and any exclusions and limitations that apply to these types of covered medical expenses under your plan.

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

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

   e. If your coverage under the Policy is rescinded, Aetna will provide you with a 30 day advance written notice prior to the date of the rescission.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

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

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

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

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

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

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

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

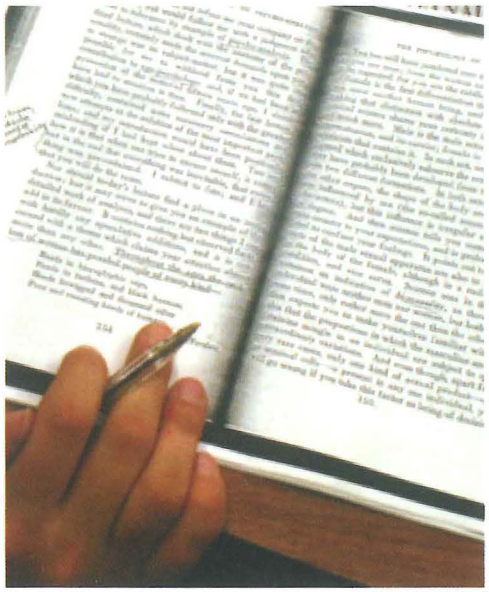
Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

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

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

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

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



What is Phased Retirement?

Phased Retirement lets you work on 50% of a full-time schedule – for up to three years from the start of Phased Retirement – while receiving 65% of your base salary, plus other benefits. If you already work part time, you will continue on your current schedule but will be paid 65% of base salary.

If you elect Phased Retirement, you must retire as of any July 31 within three academic years of the start of your Phased Retirement.

Phased Retirement

To be eligible for Phased Retirement, you must meet the following requirements as of the July 31 when your Phased Retirement starts:

- You must be a tenured faculty member
- You must be age 62 or older, and
- You must have10 or more years of service with the College.

What's Included

If you choose this option, you will teach half time (i.e., a two (2) day schedule all year) for a maximum of three academic years from the start of Phased Retirement, after which you must retire. During Phased Retirement, you will receive:

- 65% of your full-time base salary, plus any usual salary increases (Note: If you currently work part time on 50% schedule and you elect this option, you will continue to work 50% of a full-time schedule with your base salary increasing to 65% of your full-time-equivalent base salary.)
- Coverage under all active employee health insurance benefits (medical, dental, vision) for you, your spouse or domestic partner, and your eligible dependents, in which you are enrolled when Phased Retirement starts,
- Retirement Plan contributions based on 65% of your full-time equivalent base salary, and
- Life insurance coverage based on 100% of your pre-Phased Retirement base salary.

When you actually retire:

- You and your spouse or domestic partner will be eligible for subsidized post-65 retiree medical insurance upon reaching age 65 and becoming eligible for Medicare, and
- You will maintain a continuing connection with Sarah Lawrence through membership in the Professor Emeritus Society for Retired Faculty as described on the following page.