MEDICAL EXPENSE POLICY

AETNA LIFE INSURANCE COMPANY
151 Farmington Avenue
Hartford, Connecticut 06156

This Policy will be construed in line with the law of the jurisdiction in which it is delivered.

This Policy is renewable at premium rates set by the Insurance Company on each renewal. See the sections “Premiums Payments”, “Terms and Termination of Your Coverage” and “Changes in Residence.”

Insurance will not be continued beyond the termination date stated in “Terms and Termination of your Coverage” section. This Policy provides benefits for certain expenses resulting from a Non-occupational Disease or Injury, as stated. You may be eligible for coverage for certain expenses resulting from Occupational Disease or Injury. See the “Type of Coverage” section.

Right of Examination

The policyholder may return this Policy to Aetna Life Insurance Company at the address shown below within 10 days after the date of delivery if not satisfied. If the Policyholder returns this Policy, it will be void from its effective date and any premium paid will be returned. This provision or the fact of its existence will not be used to defeat or reduce any other right of the Policyholder.

Aetna Advantage for Individuals and Families
Attn: Enrollment
P.O. Box 730
King of Prussia, PA 19422

IMPORTANT NOTICE

Please read the copy of the application attached to this Policy. If any information on it is not correct and complete, please write to Aetna Life Insurance Company at the address above within 10 days.

Your application has now become part of the Policy, which has been issued on the basis that the information given in your answers to all questions shown in the application is correct and complete. Incorrect or incomplete information could jeopardize your claim.

Your review of this application now will help prevent cases of misstatements or misunderstandings.

This policy is non-participating.

Ronald A. Williams
Chairman, Chief Executive Officer and President

Countersigned:

Licensed Resident Agent

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

Table of Contents

The Policy

Policyholder or Parent/Guardian of:	**FirstName MidleInt LastName**
Policy Number:	**MemberID**
Coverage Type:	**TypeOfCoverage**
Effective Date of Policy:	**EffectiveDate**
Initial Premium Period	**EffectiveDate to TermOfCoverage**
Premium for the Initial Period:	**$IntPremium**
Premium Due Date:	**The 1st or 15th day of each succeeding calendar month**

NOTICE: Written notice shall be given by U.S. Mail, postage prepaid, to Aetna at:

Aetna Advantage for Individuals and Families
Attn: Enrollment
P.O. Box 730
Blue Bell, PA 19422

This Policy is underwritten by Aetna Life Insurance Company, of Hartford, Connecticut (called Aetna). The benefits and main points of the contract for persons covered under this Policy are set forth in this Policy.

If, during the first two years of coverage under this Policy, we discover any material facts that you or your eligible family members knew, but did not disclose on your application, we will cancel your coverage under this Policy back to its Effective Date.

Eligibility

Who is Eligible for Coverage

The Policyholder is the person who is a resident of the State of California and listed as the applicant whose Application has been approved and accepted by Aetna for coverage under this Policy.

Covered Dependents are the following members of the Policyholder's family who are eligible and accepted under this Policy:

- The Policyholder's lawful spouse of the opposite sex.
- The Policyholder's domestic partner if the Policyholder and the domestic partner:

  meet the requirements under California law for entering into a domestic partnership; and

  have jointly executed and filed a Declaration of Domestic Partnership with the Secretary of State.
- Any children of the Policyholder or of the Policyholder's covered spouse or domestic partner who are under age 19.
- Any unmarried children of the Policyholder or of the covered spouse or domestic partner who are between the ages of 19 and their 23rd birthday, provided they are dependent upon them for at least half of their support. If a dependent does not meet the qualifications to remain as a dependent under this Policy, Aetna will issue a separate Policy to that dependent under his/her own social security number.
- Any of the Policyholder's or covered spouse's or domestic partner's children who continue to be both incapable of self support due to continuing mental retardation or physical handicap and are still at least one-half dependent upon the Policyholder or the covered spouse or domestic partner for support: We must receive written proof of such handicap and dependency within thirty-one (31) days of the child reaching the limiting age and as often as we may require thereafter. Two years after receipt of the initial proof, we may require no more than annual proof of the continuing handicap and dependency.
- Newborns of the Policyholder or of the Policyholder's covered spouse or domestic partner for the first thirty-one (31) days of life. TO CONTINUE COVERAGE, THE NEWBORN MUST BE COVERED AS A FAMILY MEMBER BY NOTIFYING AETNA IN WRITING WITHIN THIRTY-ONE (31) DAYS OF BIRTH AND THE POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUM CHARGES DUE EFFECTIVE FROM THE DATE OF BIRTH.
- NEWBORNS OF THE POLICYHOLDER'S DEPENDENT CHILDREN ARE NOT COVERED UNDER THIS POLICY UNLESS THE POLICYHOLDER HAS COURT ORDERED CUSTODY.
- A child being adopted by the Policyholder will have coverage up to thirty-one (31) days from the date on which the adoptive Child's birth parent or appropriate legal authority signs a written document granting the Policyholder or the covered Spouse the right to control health care for the adoptive Child, or absent this document, the date on which other evidence exists of this right. TO CONTINUE COVERAGE, THE ADOPTED CHILD MUST BE COVERED AS A FAMILY MEMBER BY NOTIFYING US IN WRITING WITHIN SIXTY (60) DAYS OF THE DATE THE POLICYHOLDER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED AND THE POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUM CHARGES DUE EFFECTIVE FROM THE DATE THE POLICHOLDER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED.

IF, DURING THE FIRST TWO YEARS OF COVERAGE UNDER THIS POLICY, WE DISCOVER ANY MATERIAL FACTS THAT YOU AND YOUR ELIGIBLE FAMILY MEMBERS KNEW, BUT DID NOT DISCLOSE ON YOUR APPLICATION, WE WILL CANCEL YOUR COVERAGE UNDER THIS POLICY BACK TO ITS ORIGINAL EFFECTIVE DATE.

Effective Date of Coverage

Coverage for the Policyholder will take effect as of the Effective Date of this Policy.

Coverage for the Policyholder's dependents will take effect on the date of the Policyholder's, if by then the Policyholder has requested Dependent's coverage, if not otherwise, stated above.

Notice of Change in Eligibility

You must notify Aetna of all changes affecting any Member's eligibility under this Policy within thirty (30) days of the change.

When the Member Becomes Ineligible

A Member becomes ineligible for coverage under this Policy when:

- The Policyholder does not pay the premiums when due, subject to the grace period.
- The Policyholder or Covered Dependent no longer resides in the State of California.
- The spouse or domestic partner is no longer married to the Policyholder.
- The child fails to meet the eligibility rules listed above (coverage will end following the date as of which the child marries, ceases to be a dependent of the Policyholder, or attains a limiting age).
- The Member fails to cancel any other coverage upon becoming covered under this Policy.
- The Member is eligible to enroll in Medicare, except that this provision will not conflict with Aetna's obligation as required by law.

Health Expense Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that Aetna will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury or disease which occurred, commenced or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

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

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

Medical Expense Coverage

Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in this Policy.

The Summary of Coverage shows the deductible, copay, covered percentages, and maximum benefits that apply to the Covered Medical Expenses described below.

This plan provides access to covered services and supplies through a network of health care providers called Preferred Care Providers. These Preferred Care Providers have contracted with Aetna, an affiliate or third party vendor to provide health care services and supplies to Aetna plan covered persons at a reduced fee called a negotiated charge. This plan is designed to lower your out-of-pocket costs when you use Preferred Care Providers. You also have the choice to access care from licensed providers outside our network. Your out-of-pocket expenses will generally be higher.

Specialists and Other Preferred Care Providers

You may directly access **specialists** and other health care professionals in the network for covered services and supplies under this Policy.

Accessing Preferred Care Providers

- You may select a Preferred Care Provider from the 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.
- If a service you need is covered under the plan but not available from a Preferred Care Provider or hospital in your area, please contact Member Servicesby email or at the toll-free number on your ID card for assistance.
- Certain health care services require certification with Aetna to verify coverage for these services. You do not need to precertify services provided by a Preferred Care Provider. Preferred Care Providers will be responsible for obtaining necessary certification for you.
- You will not have to submit medical claims for treatment received from Preferred Care Providers and facilities. Your Preferred Care Provider will take care of claim submission. Aetna will directly pay the Preferred Care Provider or facility less any cost sharing required by you. You will be responsible for deductibles, coinsurance and copays if any.

Accessing Non-preferred Care Providers

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

- Certification is necessary for certain services. Prior to receiving services from a non-preferred care provider, you are responsible for obtaining the necessary certification from Aetna. Your provider may certify your treatment for you, however you should verify with Aetna prior to the procedure, that the provider has obtained certification from Aetna. Refer to the section "Utilization and Preservice Review Procedures" for more information on the certification process.
- When you use physicians and hospitals that are not in the network you may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of covered expenses you paid directly to a non-preferred care provider. Aetna will reimburse you for a covered expense up to the recognized charge, less any cost sharing required by you.
- If your non-preferred care provider charges more than the recognized charge, you will be responsible for any expenses incurred above the recognized charge.

Covered Medical Expenses

They are the expenses for certain hospital and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

Hospital Expenses

Inpatient Hospital Expenses

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

Outpatient Hospital Expenses

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

Emergency Room Treatment

Emergency Care

If treatment:

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

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

Non-Emergency Care

If treatment:

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

no benefits will be payable.

Skilled Nursing Facility Expenses

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

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a skilled nursing facility. This does not include private or special nursing, or physician's services.
- Medical supplies.

Home Health Care Expenses

Home health care expenses are covered if:

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

Home health care expenses are charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Policy if the person had been confined in a hospital or skilled nursing facility:

  Medical supplies;
  Drugs and medicines prescribed by a physician.

Lab services provided by or for a home health care agency.

- Medical social services.

A visit is defined as 4 hours or less of service provided. The maximum to the number of visits covered in a calendar year is shown in the Summary of Coverage.

Ambulance Expenses

Charges to transport a member from or to a hospital when medically Necessary including emergency medical transportation services and ambulance provided through the 911 emergency response system. The Maximum Ambulance Benefit is shown in the Summary of Coverage.

Outpatient Surgical Expenses

Charges made:

- by a surgery center; or the outpatient department of a hospital.
- by a physician.

Outpatient Services and Supplies

- Services and supplies furnished by the surgery center or by a hospital on the day of the procedure.
- Services of the operating physician for performing the procedure and for:

  related pre and postoperative care; and the administering of an anesthetic.

- Services of any other physician for the administering of an anesthetic. This does not include a local anesthetic.

Hospice Expenses

Charges made for the service furnished to a Member for Hospice Care when given as a part of a Medicare Accredited Hospice Care Program are included as Covered Medical Expenses.

Physical Therapy/Chiropractic Therapy/Spinal Manipulation

In any one calendar year not more than the Calendar Year visit maximum will be payable for expenses incurred for:

- manipulative (adjustive) treatment; or
- other treatment.

Other Covered Medical Expenses

- Charges made by a physician.
- Diagnostic lab work and X-rays.
- X-ray, radium, and radioactive isotope therapy.
- Anesthetics and oxygen.
- Rental of durable medical and surgical equipment, including ostomy and laryngectomy prosthetic devices and related supplies. In lieu of rental, the cost for the following may be covered:

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

  a change in the Member's physical condition; or
  it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

- Artificial limbs and eyes.
- Orthopedic shoes, or other devices to support the feet, necessary to prevent complications of diabetes.
- Hearing aids, subject to any limitations outlined in the Summary of Coverage.

Routine Screening for Cancer*

Even though not incurred in connection with disease or injury, Covered Medical Expenses include charges incurred for:

- routine screening mammograms;
- one gynecological exam (including a Human Pappiloma Virus (HPV) screening per calendar year;
- one Pap smear per calendar year;
- colorectal screening, consisting of: for members age 50 or more, one occult blood stool test very calendar year; flexible sigmoidoscopy every 5 years; colonoscopy every 10 years; double contrast enema every 5 years; or any combination of the most reliable, medically recognized screening tests available.
- For Members who are deemed at high risk for colon cancer because of: a family history of familial adenomatus polyposis; family history of hereditary nonpolyposis colon cancer or polyps; or a background, ethnic lifestyle such that the attending physician believes the Member is at an elevated risk, screening by colonoscopy, barium enema or any combination of the most reliable, medically recognized screening tests available at a frequency determined y the Member's physician.
- For a Member age 40 or over, in connection with an exam each calendar year for screening for cancer of the prostate, including a digital rectal exam, and a prostate antigen (PSA) test.

*** In addition to routine screening mammograms, any other Necessary mammograms will also be a Covered Medical Expense under this Policy.**

Mastectomy and Related Procedures

Covered Medical Expenses include hospital and physician services related to mastectomy, including the following services in connection with breast reconstruction and post-mastectomy care:

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

The minimum length of confinement following a mastectomy for which coverage is provided is the number of days determined by the attending physician to be necessary upon evaluation of the patient.

Coverage is provided for a post-discharge physician office visit or in-home nurse visit within the first 48 hours after discharge.

Covered Medical Expenses are payable on the same basis as for any other medical condition.

Mouth, Jaws and Teeth

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

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

For these expenses, "physician" includes a dentist.

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out:
  - teeth 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.

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

Preventive Health Expenses

Although not incurred in connection with a disease or injury, Covered Medical Expenses include the following Preventive Heath Expenses. Benefits are subject to a Calendar Year maximum shown in the Summary of Coverage. No deductible is applicable to Preferred Care.

For Members to Age 18

This Policy covers immunizations against: Diphtheria; Hepatitis B; Human Pappiloma Virus (HPV) screening; Measles; Mumps; Pertussis; Polio; Rubella; Tetanus; Varicella; Haemophilus Influenzae B; and Hepatitis A.

For Members Age 18 or Over

This Policy covers one routine exam every 365 days.

Coverage for Screening for Blood Lead Levels

Covered medical expenses include screening for blood lead levels for covered children.

Coverage for General Anesthesia and Facility Charges for Dental Procedures in a Hospital

Coverage for general anesthesia and associated facility charges for dental procedures in a hospital or surgery center when the clinical status or underlying medical conditions require general anesthesia in a hospital or surgery center.

Coverage is available under this provision:

- Covered person is under seven years of age;
- Covered person is developmentally disabled, regardless of age;
- Covered person's health is compromised and general anesthesia is medically necessary, regardless of age.

Coverage for Cancer Clinical Trials

This Policy covers charges incurred by a Member for routine patient costs for participation in a cancer clinical trial as a result of a treatment provided for a life-threatening disease. The treatment must be provided in a clinical trial approved or funded by:

- One of the National Institutes of Health (NIH);
- An NIH cooperative group or an NIH center ("cooperative group" means a formal network of facilities that collaborate on research projects and have established NIH-approved Peer Review Program operating within the group, and includes, but is not limited to: the National Cancer Institute Cooperative Group and the National Cancer Institute Community Clinical Oncology Program);
- The federal Food and Drug Administration (FDA) in the form of an investigational new drug.
- An institutional review board of an institution in the State which has a multiple project assurance contract approved by the Office of Protection research Risks of the NIH;

"Cancer clinical trial" means: an organized, systematic, scientific study of therapies, tests or other clinical interventions for the purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human beings. A clinical trial for the prevention of cancer is eligible only if it involves a therapeutic intervention and is a phase III clinical trial approved by one of the entities listed above.

The clinical trial must meet the following requirements:

- The subject of the trial must be the evaluation of an item or service that falls within the Covered Medical Expenses of this Policy and not be specifically excluded.
- The trial must not be designed exclusively to test the toxicity or disease pathopsychology
- The trial must have a therapeutic intent.
- Trials of therapeutic interventions must enroll patients with diagnosed disease.
- The principal purpose of the trial is to test whether the intervention potentially improves the participant's health outcomes.
- The trial is well supported by available scientific and medical information; or is intended to clarify or establish the health outcomes of interventions already in common clinical use.
- The trial does not unjustifiable duplicate existing studies.
- The trial is in compliance with federal regulations relating to the protection of human subjects.

Coverage for Diabetes

Covered Medical Expenses include charges for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes. If a Member is diagnosed with diabetes, Covered Medical Expenses include the following to the extent not already covered under other parts of this Policy:

- The necessary equipment, in accordance with the Member's treatment plan;
- Lab and diagnostic tests;
- Drugs and supplies prescribed by the physician

Also included as Covered Medical expenses are charges for outpatient self-management training the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes if prescribed by a licensed health care professional who has the required state authority to prescribe such training.

Outpatient self-management training includes, but is not limited to education and medical nutrition therapy. The training must be provided by a registered or licensed health care professional trained in the care and management of diabetes and authorized to provide such care.

Benefits will be payable for:

- Initial training visits after diagnosis, including but not limited to counseling in nutrition and proper use of equipment and supplies, to a maximum of ten hours.
- Training and education as a result of a later diagnosis by a physician of a significant change in the Member's symptoms or condition which requires a modification of the member's self-management program, up to a maximum of four hours;
- Training and education that is necessary because of the development of new techniques and treatments for diabetes, up to a maximum of four hours.

Coverage for Medical Services Without Person-To-Person Contact

Covered expenses include covered medical services without person-to-person contact from a covered provider.

Coverage for AIDS Vaccine

Covered expenses include a vaccine for acquired immune deficiency syndrome (AIDS) that has been approved for marketing by the federal Food and Drug Administration (FDA) and that is recommended by the United States Public Health Service.

Phenylketonuria (PKU)

Testing and formulas necessary for the treatment of phenylketonuria (PKU).

Non-Emergency Care In An Emergency Room

If treatment:

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

Covered Medical Expenses for charges made by the hospital for such treatment will be paid at the rate shown in the Summary of Coverage.

No benefit will paid under any other part of the Policy for charges made by a hospital for care in an emergency room that is not emergency care.

In the case of Emergency Care, you, the Member's physician or the hospital must call the number shown on your ID card to obtain certification for the emergency admission.

It is important to call no later than 48 hours following the start of a confinement as a full-time inpatient which requires an emergency admission, unless it is not possible to request certification within that time. In that case, it must be done as soon as reasonably possible.

If in the opinion of the Member's physician, it is necessary for the Member to be confined for a longer time than already certified, you must call the number shown on your ID card to certify more days of confinement. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent to the hospital or treatment facility. A copy will be sent to you and to the physician.

Severe Mental Illness  88

Covered expenses include charges for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child. Covered Medical Expenses include the following to the extent not already covered under other parts of this Policy.

- Outpatient services
- Inpatient Hospital Services
- Partial Hospital Services
- Prescription Drugs

"Severe Mental Illness" includes:

- Schichophrenia.
- Schizoaffective disorder
- Bipolar disorder (manic depressive illness).

- Major Depressive Disorders.
- Panic Disorder.
- Obsessive-compulsive Disorder
- Pervasive developmental disorder or autism.
- Anorexia nervosa.
- Bulimia nervosa.

"Serious Emotional Disturbances of a child" means that the child has one or more mental disorders outlined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to developmental norms and who as a result of the mental disorder has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur: the child is at risk of removal from home or has already been removed from the home, the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Transplant Services

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

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 365 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 365 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g. a liver transplant with subsequent heart transplant).

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

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

The plan covers:

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

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

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 365 days from the date of the transplant; or (2) upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The 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 within 365 days from the date of the transplant event.

If you are a participant in the Institutes of Excellence™ (IOE) program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any Covered Medical Expenses you incur from an IOE facility will be considered in-network care expenses.

To ensure coverage, all transplant procedures need to be precertified by Aetna. Refer to Utilization and Preservice Review Procedures for details.

Refer to the Summary of Coverage for the transplant expense maximums and payment limits.

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. ; and
- Services and supplies furnished by a non-IOE facility.
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.
- Charges for transplant expenses incurred within the first 12 months of continuous coverage under the plan. This limitation may be reduced by the number of months of prior transplant coverage you have on the Effective Date of Coverage under the plan**,** if you have at least 12 months of such prior **t**ransplant coverage. This limitation will not apply for a newborn child during the first12 months of lifeotherwise eligible for coverage under the plan and requiring a transplan**t** at birth.

Network of Transplant Specialist Facilities

Through the Institutes of Excellence™ (IOE) network, you will have access to a provider network that specializes in transplants. Benefits may vary if an Institute of Excellence™(IOE) facility or non-IOE or Non-Preferred Care Provider is used. 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.

Explanation of Important Policy Provisions

Inpatient Hospital Deductible

If shown in your Summary of Coverage, this is the amount of Inpatient Hospital Expenses you pay for each hospital confinement of a Member. Not more than 3 Inpatient Hospital Deductibles will apply to all confinements of a Member in any one calendar year.

The Inpatient Hospital Deductible will only be applied once to all hospital confinements, regardless of cause, which are separated by less than 10 days.

Expenses used to meet the Inpatient Hospital Deductible cannot be used to meet any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Inpatient Hospital Deductible.

Calendar Year Deductible

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

Family Deductible Limit

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

Hospital Emergency Room Copay

A separate Hospital Emergency Room Copay applies to each visit for emergency care, by a Member in a hospital's emergency room unless the Member is admitted to the hospital as an inpatient within 24 hours after a visit to a hospital emergency room.

Prescription Drug Benefits (Out of Hospital)

Any expenses incurred under provisions of this section apply toward meeting the separate Prescription Drug deductible but do not apply toward the Member's Calendar Year deductible or Payment Limits.

Benefits may be subject to copayments, deductibles, calendar year maximums, dispensing limits and prior authorization requirements, if any.

- Drugs, medicines or medications that under federal or state law, may be dispensed only by prescription from a health care practitioner, and
- Limited to a maximum of a supply based on the FDA approved dosage, regardless of manufacturers' packaging, per prescription or refill at a retail pharmacy; and
- Limited to a maximum of a supply based on the FDA approved dosage, regardless of manufacturer packaging, per prescription or refill received from a mail order pharmacy, and,
- Drugs, medicines or medications that must be included on the drug list; and
- Insulin and diabetic supplies on prescription, which include:
  - Strips
  - Glucose tabs
  - Lancets and lancet devices
  - Test solutions
  - Syringes
  - Alcohol swabs
  - Insulin delivery devices
  - Blood glucose monitors
- Hypodermic needles or syringeson prescriptionfor use with insulin or self administered injectable drugs:
  - Hypodermic needles and syringes used in conjunction with covered level 3 drugs and level 4 drugs may be available at no cost to the covered person and
  - Self-administered injectable drugs approved by us and
  - Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases; formulas necessary for the treatment of a disease or condition.

Certification for Certain Prescription Drugs

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

When one or more of the prescription drugs shown in the List of Prescription Drugs Requiring Certification (see below) is dispensed, expenses incurred will be payable as follows:

- If certification has been requested and the drug is necessary: Benefits will be payable at the applicable Payment Percentage.
- If certification has not been requested and the drug is necessary: No benefits will be payable.
- If the drug is not necessary: No benefits will be payable whether or not certification has been requested.

Certification Procedures

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

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

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

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

List of Prescription Drugs Requiring Certification
Refer to the Medication Formulary Guide for the list of prescription drugs that require certification, or call the number shown in your ID Card. Please note that the List of Prescription Drugs Requiring Certification is subject to periodic review and modification by Aetna.

Medical Exclusions and Limitations

Charges For Which You Are Not Legally Obligated to Pay

Charges for which you have no legal obligation to pay or for which no charge would be made if you did not have health plan or insurance coverage, except services received at a non-governmental charitable research hospital.

Charges for services rendered by Relatives

Charges for professional services received from a person who lives in the Member's home or who is related to the Member by blood, marriage or adoption.

Charges for Unlisted Services

Charges for services and supplies not specifically listed in this Policy as Covered Medical Expenses.

Charges for Ambulance Services

For routine transportation to receive outpatient, inpatient or professional services.

Charges for Court ordered services

Charges for court ordered services or those required by court order as a condition of parole or probation, other than for medically Necessary services provided by Preferred Care Providers.

Charges for routine immunizations

Charges for routine immunizations, unless otherwise specified in this Policy.

Charges for immunizations

Charges for immunizations, including those required by foreign travel for covered persons of any age, except as otherwise described in this Policy.

Cosmetic Surgery

Cosmetic surgery or other services that are performed to alter or reshape normal structures of the body in order to improve appearance. Cosmetic surgery does not include reconstructive breast surgery following a mastectomy, including (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, in a manner determined by the attending physician and patient to be appropriate.

Custodial Care

Custodial care is care that does not require the services of trained medical or health professionals, such as, but not limited to, help in walking, getting in and out of bed, bathing, dressing preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered. Domiciliary, or rest cures for which facilities, and/or services of a general acute hospital are not medically required including resident treatment centers are also excluded.

Dental Services

Dental services, including dentures, bridges, crowns, caps, clasps, habit appliances, partials, or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums. Dental Implants: materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of implants. Orthodontic Services: Braces, other orthodontic treatment appliances, orthodontic services.

Diagnostic Admissions

Diagnostic admissions, inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Excess Amounts

Any amounts in excess of the maximum amounts shown in the Summary of Coverage.

Experimental

Any medical, surgical and /or other procedures, services, products, drugs or devices including implants, whose use is mainly limited to laboratory and /or animal research. Aetna has the sole discretion to make this determination.

Food or Dietary Supplements

Food or dietary supplements, except for formulas and special modified food products as specifically stated in this Policy. They must be prescribed by and administered under the supervision of a physician for the therapeutic treatment of a condition.

Genetic Testing

Charges for counseling or services.

Government Services

Any services provided by a local, state or federal government agency except when payment under this Policy is expressly required by federal or state law.

Hearing Tests (Routine)

Routine hearing tests except as provided for under this Policy.

Infertility Treatment

Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

Investigational

Any medical, surgical and /or other procedures, services, products, drugs or devices (including implants): (a) which do not have final approval from the appropriate governmental regulatory body (but see exception under the definition of "Investigational, .Experimental procedures in the Glossary) ; or (b) which are not supported by scientific evidence which permits conclusions concerning the effect of the service, drug or device on health outcomes; or (c) which do not improve the health outcome of the patient treated; or (d) which are not beneficial as any established alternative; or (e) whose results outside the investigational setting cannot be demonstrated or duplicated; or (f) which are not generally approved or used by physicians in the medical community. Aetna has the sole discretion to make this determination.

Non-Duplication of Medicare

Any services to the extent that you are entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid. Any services for which payment may be obtained from any local, state or federal government agency. If you are eligible for Part B of Medicare and do not enroll in it, we will still reduce the benefits payable under this Plan as if you were enrolled in Part B, and Medicare Part B benefits were paid. Veteran's Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.

Not Medically Necessary

Charges for services or supplies that are not defined as medically Necessary.

Nutritional Counseling, except for Diabetes.

Orthotics except as needed for Diabetes.

Outpatient Speech Therapy

Outpatient speech therapy, except following surgery, injury or non-congenital organic disease.

Personal Comfort Items

Items which are furnished primarily for your personal comfort or convenience, air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators, and supplies for comfort, hygiene or beautification.

Pre-existing Conditions

No payment will be made for services or supplies for the treatment of a Pre-existing Condition during a period of six (6) months following your effective date. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber, spouse or domestic partner. Also, if you were covered under Creditable Coverage as defined by the regulations within 63 days of becoming covered under this Plan, the time spent under the Qualifying Prior Coverage will be used to satisfy, or partially satisfy, the six (6) month period**.**

Pregnancy

No payment will be made for services or supplies for pregnancy with the exception of complications of pregnancy.

Private Duty Nursing.

S.A.D. Seasonal Affective Disorder

Light treatment for Seasonal Affective Disorder (S.A.D.)

Sex Changes

Charges for procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex changes.

Substance Abuse

Treatment of Substance Abuse, including nicotine use.

Telephone and Facsimile Consultations

Charges for consultations provided by telephone or facsimile machines.

Vision Care

Charges for optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams and routine eye refractions, except as specifically stated under the benefit sections of this Policy. Certain Eye Surgeries: Any eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), astigmatism and /or farsightedness (presbyopia). Lasik surgery and any other procedures designed to surgically correct refractory conditions.

War

Conditions caused by an act of war, including those caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Weight Reduction

Coverage is not provided for the following charges:

Those for weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction**,** regardless of the existence of comorbid conditions.

Workers' Compensation

Any condition for which benefits are recovered or can be recovered, either by any workers' compensation law, employer's liability law or work related disease law.

Not Covered

- Charges for Covered Medical Expenses incurred before the Member's coverage Effective Date or during an inpatient stay that began before the Member's coverage Effective Date. Charges for Covered Medical Expenses incurred after the Member's coverage under this Policy ends.
- Charges in excess of any Negotiated Charge for a service or supply.
- Charges in excess of the recognized charge.
- Charges for services exceeding the amount of benefits available for a particular service.
- Charges for services provided when a premium is past due, and the payment has not been received.
- Charges for services received by an individual who is not eligible for benefits.

Prescription Drug Exclusions and Limitations

IN ADDITION TO ANY LIFETIME MAXIMUMS, LIMITATIONS ON PRE-EXISTING CONDITIONS OR ANY OTHER EXCLUSIONS OR LIMITATIONS DESCRIBED IN THIS POLICY, CHARGES FOR PRESCRIPTION DRUGS WILL NOT BE COVERED FOR:

- Drugs or medications which may be obtained without a physician's prescription, except insulin and niacin for cholesterol lowering.
- Prescription drugs which have non-prescription equivalents.
- Non-medicinal substances or items. Including: Pharmaceuticals to aid smoking cessation (e.g., Nicorette) or any prescription product containing nicotine.
- Dietary supplements, herbs, vitamins, cosmetics, health or beauty aids, or similar products which are not FDA approved to treat, diagnose, prevent of cure a medical condition. However, amino acid modified preparations, low protein food products and specialized formulas for treatment of inherited metabolic and other conditions or diseases are covered.
- Drugs taken while you are in a hospital, skilled nursing facility, rest home, sanitarium, convalescent hospital or similar facility.
- Any expense incurred in excess of the Negotiated Fee at a Participating Pharmacy.
- Any drug labeled "Caution, limited by Federal law to investigational use" or any drug or medication prescribed for experimental indications. This will not apply to any drug prescribed for the treatment of cancer for which the drug has not been approved by the federal FDA if such drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following standard reference compendia: (1) the U.S. Pharmacopeia Drug Information Guide for the Health Care Professional; (2) the American Medical Association's Drug Evaluations; or (3) the American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information.
- Syringes and/or needles, except those specifically prescribed by a physician for dispensing covered medications.
- Durable medical equipment, devices, appliances, and supplies, except lancets and test strips for use in the monitoring of diabetes.
- Immunizing agent, biological sera, blood, blood products or blood plasma.
- Oxygen.
- Professional charges in connection with administering, injecting or dispensing of drugs. Infusion medications.
- Drugs and medication dispensed or administered in an outpatient setting, including, but not limited to outpatient hospital facilities and doctor's offices.
- Drugs used for cosmetic purposes (e.g., Retin-A for wrinkles) and dermatological or hair growth stimulants.
- Drugs used for the primary purpose of treating infertility.
- Drugs used for weight loss or weight control.
- Drugs obtained outside of the United States which are not approved by the FDA.
- Allergy desensitization products, allergy serum.
- All infusion therapy except self-administered injectables, and aerosols, is excluded.

- Non-formulary medications are not covered, unless:

  a physician denotes medical necessity by writing, “Do not substitute” or “Dispense as written” on the prescription order;

  The Member was covered under the Policy and/or using the medication for a chronic illness prior to its removal from the list; or

  The Member was covered under the Policy prior to its removal from the list.

  - Treatment of impotence and/or sexual dysfunction.
  - Anabolic steroids.
  - Treatment for Onychomycosis (nail fungus).

Utilization and Pre-service Review Procedures

Utilization Review Procedures

Aetna evaluates and determines the appropriateness of medical care resources utilized by covered persons. To accomplish these goals, Aetna has developed a comprehensive Patient Management Program which incorporates a wide range of:

- commercially developed and nationally recognized guidelines and criteria;
- reference tools; and
- published medical literature.

These documents assist Aetna in determining the appropriate level of coverage for services. In addition, Aetna has developed internal guidelines to monitor the use of, or evaluate, the clinical:

- necessity;
- appropriateness;
- efficacy; or
- efficiency of;

health care services, procedures or settings. Such internal guidelines include, but are not limited to: second opinion; certification of admissions or of certain procedures; concurrent review; case management; discharge planning; or retrospective review.

Local quality committees review, update and adopt the review criteria at least annually. This may occur more frequently if necessary. These committees are composed of community practicing physicians and health plan staff.

Aetna maintains and makes available procedures for providing notification of its determinations for:

- Initial determinations regarding proposed:

  Hospital; convalescent; and treatment facility admissions;
  Certain procedures and treatments; or
  Home Health Care; Hospice Care; and Skilled Nursing Care.

- Concurrent review determinations regarding continued stay or additional services.
- Reconsideration of an adverse determination in any case involving an initial determination or a concurrent review determination.

To determine the status; or outcome of any utilization review decision; you may call Member Services at the toll-free telephone number on your I.D. card.

The procedures to follow for certification appear below.

Certification For Hospital Admissions

If:

- a Member becomes confined in a hospital as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is necessary;

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

As to Hospital Expenses incurred during the confinement:

If certification has been requested and denied:

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

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

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

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

As to all other Hospital Expenses:

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

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

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

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

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

- As to other Covered Medical Expenses:

  Benefits will be paid at the Payment Percentage.

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

Certification of days of confinement can be obtained as follows:

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

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

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

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

Certification For Skilled Nursing Facility Admissions, Home Health Care Expenses, Hospice Care Expenses

If a Member incurs Covered Medical Expenses:

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

it has not been certified that:

- such confinement or any day of it is necessary; or
- such other services or supplies (either specifically or as a part of a planned program of care) are necessary,

such Covered Medical Expenses will be paid only as follows:

- As to Skilled Nursing Expenses and Hospice Care Facility Expenses incurred while confined in a skilled nursing facility or a hospice facility:

  If certification has been requested and denied:

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

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

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

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

- As to all other Skilled Nursing Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:

  Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses. Benefits for all other such expenses will be paid at the Payment Percentage.

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

Skilled Nursing Facility Expenses or Hospice Care Facility Expenses, incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses. Benefits for all other such expenses, incurred during the confinement, will be paid at the Payment Percentage.

- As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.
- As to Covered Medical Expenses incurred for services or supplies either as stated or as a part of a planned program of care for home health care or hospice care while not confined as an inpatient or skilled nursing care:

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

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

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

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

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

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

  Skilled Nursing Facility Expenses for room and board; or

  Hospice Care Facility Expenses for room and board.

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

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

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

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

If:

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

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

Certification For Hospital And Treatment Facility Admissions

If:

- a Member incurs Covered Medical Expenses:

  while confined in a hospital or treatment facility;

  for the effective treatment of alcoholism, drug dependency or a severe mental disorder; and

- it has not been certified:

  such confinement (or any day of it) is necessary; and the confinement has not been ordered and prescribed by a physician who is a Preferred Care Provider.

  such Covered Medical Expenses will be paid only as shown below.

- As to Inpatient Hospital and Treatment Facility Expenses incurred for board and room:

If certification has been requested and denied:

No benefits will be paid for Inpatient Hospital Expenses or Treatment Facility Expenses incurred for board and room.

Benefits for all other Inpatient Hospital Expenses or Treatment Facility Expenses incurred during the confinement will be paid at the Payment Percentage after any applicable deductible.

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

Inpatient Hospital Expenses or Treatment Facility Expenses, and expenses incurred for the service of a physician during the confinement up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other such expenses incurred during the confinement will be paid at the Payment Percentage after any applicable deductible.

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

Certification of days of confinement can be obtained as follows:

If the admission is not an emergency, you must get the days certified by calling the number shown on your ID card.

This must be done before the date the Member is scheduled to be confined as a full-time inpatient.

In the case of Emergency Care, you, the Member's physician or the hospital must get the days certified by calling the number shown on your ID card. This must be done:

Not later than 48 hours following the start of a confinement as a full-time inpatient which requires an emergency admission; unless it is not possible to request certification within that time. In that case, it must be done as soon as reasonably possible.

If in the opinion of the Member's physician, it is necessary for the Member to be confined for a longer time than already certified, you must call the number shown on your ID card to certify more days of confinement. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent to the hospital or treatment facility. A copy will be sent to you and to the physician.

Certification For Certain Procedures and Treatments

Certification of the necessity of certain procedures and treatments is required:

- before the procedure is performed; or
- before the treatment starts.

When any of the procedures or treatments shown below are to be performed on an inpatient or outpatient basis, Covered Medical Expenses incurred in connection with the performance of the procedure or treatment will be payable as follows:

- If the procedure or treatment is not **necessary**:

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

- If certification has been requested or the **physician** performing the procedure or treatment is a **Preferred Care Provider**, and the procedure or treatment is **necessary**:

  Benefits will be payable at the Payment Percentage.

- If certification has not been requested and the procedure or treatment is **necessary** but will be performed by a **physician** who is not a **Preferred Care Provider**:

  Expenses incurred in connection with its performance, up to the Excluded Amount, will not be considered to be Covered Medical Expenses.

  Benefits for Covered Medical Expenses in excess of the Excluded Amount will be payable at the Payment Percentage.

A **physician** who performs the procedure or treatment on referral by a Preferred Care Provider will be considered to be a Preferred Care Provider only for the purpose of certification. For the purpose of determining benefits for the performance of the procedure or treatment, the physician will not be deemed to be a Preferred Care Provider.

List of Procedures and Treatments
A list of procedures or treatments require certification before the procedure or treatment is performed shall be available upon requesting by calling Member Services at the toll-free number on your ID card or by accessing www.aetna.com. Even though the procedures or treatments are most often done on an outpatient basis, certification is required whether the procedure or treatment will be performed:

- on an inpatient basis; or
- on an outpatient basis.

If the physician performing the treatment or procedure, or initiating the referral for its performance, is a Preferred Care Provider:

- Certification will be requested by the Preferred Care Provider.

If the physician who will perform the procedure or treatment is not a Preferred Care Provider:

- You or the provider performing the procedure or treatment, must call the toll-free number shown on your ID card to request certification.

Notice of Noncertification.

A written notification of a noncertification shall include, in clear terms, all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. Aetna shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request.

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 or supply or benefit.

Such Adverse Benefit Determination may be based on, among other things:

- The covered person's eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not Medically Necessary.

Appeal: An oral or writtenrequest to Aetna to reconsider an Adverse Benefit Determination.

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

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

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

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize the life of the covered person;
- jeopardize the ability of the covered person to regain maximum function;
- cause the covered person to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

CLAIM DETERMINATIONS –Health Coverage

Urgent Care Claims

Aetna will make notification of an urgent care claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The **claimant** has 48 hours after receiving such notice to provide Aetna with the additional information.

Aetna will notify the **claimant** within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the covered person within the first 15 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The covered person will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the covered person within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension

Following a request for a Concurrent Care Claim Extension, Aetna will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a Concurrent Care Claim Extension.

Concurrent Care Claim Reduction or TerminationAetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for the covered person to file an appeal.

CLAIM DETERMINATIONS

Aetna will make notification of a claim determination as soon as possible but not later than 90 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 90 calendar day claim determination period is required. Such an extension, of not longer than 90 additional calendar days, will be allowed if Aetna notifies the covered person within the first 90 calendar day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

COMPLAINTS

If you are dissatisfied with the service you receive from the Plan or want to complain about a participating provider you must call or write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an Appeal if Aetna gives notice of an Adverse Benefit Determination. This Plan provides for two levels of Appeal. It may also provide an option to request an external review of the Adverse Benefit Determination.

You have 180 calendar days with respect to Health claims following the receipt of notice of an Adverse Benefit Determination to request your level one Appeal. Your appeal may be submitted orally or in writing and should include:

- Your name;
- A copy of Aetna's notice of an Adverse Benefit Determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Send in your appeal to 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.

Send your appeal to the address shown on the notice of Adverse Benefit Determination, or you may call in your appeal using the toll-free telephone number listed on such notice.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna.

Level One Appeal –Health Claims

A level one appeal of an Adverse Benefit Determination shall be provided by Aetna personnel not involved in making the Adverse Benefit Determination.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

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

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for an Appeal.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for an Appeal.

Level Two Appeal Health Claims

If Aetna upholds an adverse benefit determination at the first level of appeal, and the reason for the adverse determination was based on medical necessity or experimental or investigational reasons, you or your authorized representative have the right to file a level two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level one Appeal.

A level two Appeal of an Adverse Benefit Determination of an Urgent Care Claim shall be provided 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.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

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

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for level two Appeals.

Post-Service Claims

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

Exhaustion of Process.

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

- contact the California Department of Insurance to request an investigation of a complaint or **Appeal**; or
- file a complaint or **Appeal** with the California Department of Insurance; or
- establish any:

  litigation;
  arbitration; or
  administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

External Review Process

Applicable if 30 or more days has passed during the Appeals Process or you have exhausted your Appeals, whichever occurs first.

Definitions

For the purposes of this section, the following words and phases will have the following meanings:

1. External Review: A review of a decision by Aetna to deny coverage of or reimbursement for a medical treatment or service, on the basis that it is not medically necessary or that it was experimental or investigational, which is otherwise a **Covered Expense,** by an Independent Review Organization upon your request or your authorized representative, and the organization's subsequent decision to uphold or reverse the denial of such coverage or reimbursement made by Aetna..

2. Independent Medical Review: A review by and Independent Medical Review Organization authorized by the California Department of Insurance under the Independent Medical Review System.

3. Internal Review: The Complaint and Appeal Procedures established by Aetna for an internal reevaluation of an initial decision to deny coverage of or reimbursement for a medical treatment or service that is otherwise a **Covered Expense**, and the subsequent decision by Aetna to grant or deny such coverage or reimbursement. The Appeals and Complaint Procedures are set forth in this **Certificate**.

4. Your Authorized Representative: An individual designated through your expressed written consent to represent your interests, including, but not limited to, your **Physician**.

Eligibility

You will have the right to an Independent Medical Review of a decision by AETNA to deny coverage of, or reimbursement for, a medical treatment or service to you on the basis that it was not medically necessary or it was experimental or investigational, and that is otherwise a **Covered Expense** when:

1. Your provider recommended a health care service as medically necessary;

2. You received urgent care or emergency services that your provider determined was medically necessary;

3. You have been seen by a contracting provider for the diagnosis or treatment for which you seek an independent review;

4. All applicable Complaint and Appeal Procedures established by Aetna, as outlined in this policy, have been exhausted or 30 days has elapsed, whichever occurs first; The request for the Independent Medical Review must be made within 6 months of Aetna's upholding its decision within the appeals/grievance process;

5. The denial is based upon a determination by Aetna that the service or treatment is not **Medically Necessary**, medically appropriate or medically effective or;

6. The denial is based upon a determination by Aetna that the service or treatment was experimental or investigational.

Reconsideration of Additional Information

Aetna may, at its discretion, determine that additional information provided by you or your authorized representative or your **Physician** justifies a reconsideration of the decision to deny coverage or reimbursement. Upon notice to you or your authorized representative and the **Independent Medical Review**, a subsequent decision by Aetna to grant coverage or reimbursement based upon such reconsideration will terminate the External Review.

Informed Consent

In order to submit a request for and External Review by an Independent Medical Review Organization, an application Form 306 must be completed and submitted to the California Department of Insurance. By signing the application, you or your authorized representative acknowledges that a copy of the terms and conditions of the Independent Medical Review has been reviewed and understood and that you or your authorized representative consents to such terms and conditions.

Request for External Review Procedures

1. When you and your authorized representative receive the final adverse determination letter from Aetna at the completion of **Aetna's** internal Complaint and Appeal Procedures described in this policy, Aetna will enclose a Request for External Review Form, Form 306. A request for an Independent Medical Review of a decision by Aetna to deny coverage or reimbursement for a service or treatment must be initiated in writing by you or your authorized representative at the completion of all internal appeals or 30 days whichever occurs first.
2. If the California Department of Insurance determines that your request qualifies, you and Aetna will be notified. In most cases Aetna will be required to provide all relevant documents as well as medical records to the Independent Medical Review Organization within 3 business days. Review of your case will be completed, in writing, within 30 days.

3. Once the Independent Medical Review Organization makes a decision, written determination will be sent to Aetna, the California Insurance Commissioner and you. The following information must be included in the determination: your medical condition, the documents reviewed and the finding that are relevant to you request for review.

4. Insurance Commissioner will immediately adopt the Independent Medical Review Organization decision and the California Department of Insurance will notify Aetna and you that the recommendation of the Independent Medical Review Organization is binding on Aetna.

Extraordinary Circumstances

If there is a serious or imminent threat to your health, your physician or medical professional or the California Department of Insurance may certify, in writing, that an imminent and serious threat to the health may exist, including but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of your health. The Independent Medical Review Organization must make its determination within 3 days of receiving the proper case information. Aetna must deliver all necessary documents and information within 24 hours of the California Department of Insurance's approval of your request**.**

Premium Payments

The first premium for this Policy is due on the Effective Date of the Policy. It is for the Initial Premium Period. Each Premium Period will end at 12 o'clock midnight, standard time, at the Policyholder's home.

At the end of a Premium Period, when there is a Policyholder under this Policy and Aetna has not furnished notice of non-renewal, this Policy may be renewed for a new Premium Period. The new Premium Period will run from the end of the prior Premium Period and will be of the same length as the prior Premium Period.

Premium charges are based upon attained age, at the rates then in force. Premium charges for family coverage are based on the attained age of the older spouse. Aetna will recalculate attained age for each billing and premium charges will be automatically adjusted to the new rate. If coverage for a newborn child becomes effective on other than the first day of a Premium Period, any premium which applies for such coverage will be due from that date. It will be figured on a pro-rata basis.

If premiums are not paid by the Premium Due Date, and before the end of the Grace Period, you will be subject to a late charge of -$25 The charge will appear on the next billing statement.

Aetna may change by class at any renewal date the tale of premiums for policies of this form.

In the event of any changes in premium, payment of the premium by the Policyholder shall serve as notice of the Policyholder's acceptance of such changes.

You will be responsible for an additional $50 charge for any check with is returned or dishonored by the bank as non-payable to Aetna for any reason.

Reinstatement

If your Policy is terminated for nonpayment and you wish to apply for reinstatement, you will need to submit a new application for coverage and any premiums that are past due. Aetna either may decline to permit reinstatement in its sole discretion or may permit reinstatement upon such terms and conditions as Aetna may determine appropriate in its sole discretion.

Penalties for Misrepresented Status

If it is determined that you or a covered person have misrepresented any information concerning you, your family and/or your eligibility for this plan Aetna has the right, on its sole discretion, to take any of the following actions:

- terminate the coverage or a covered person. Additionally, we shall keep all premiums paid to date, and have the right to collect, from you, those not paid at termination.
- to rescind your coverage, unless prohibited by applicable law, on one or all covered persons due to fraud or intentional misrepresentation, which materially affected our evaluation of the risk. In a rescission action we shall refund all premiums to you. However, Aetna will have the right to offset such refund, or seek separate reimbursement, for the cost of any claims paid.
- to rescind your coverage, and reissue the correct form of coverage you would have received, had the misrepresentation not been made. In this instance, we will apply all premium paid to the new coverage, and collect any difference in the premium due to the change of coverage.

We may allow you to continue your present coverage; however, we may collect the difference in premium which would have been assessed had the misrepresentation not been made.

Terms and Termination of your Coverage

The Effective Date of your coverage appears in page 4 please insert correct page of this Policy.

Coverage will not be terminated on the basis of a Member's health status or health care needs. Aetna will not require as a condition for renewal of this Policy the addition of any rider, attachment or endorsement limiting the nature and extent of the benefits provided under it. If coverage is terminated, Aetna will refund any premiums paid for that period after the termination date, minus the cost of Covered Medical Expenses provided to a Member during this period.

Aetna may terminate, cancel or decline to renew this Policy in the event of any of the following:

- Discontinuance of this class of policies in its entirety, for reasons approved by the Insurance Department of the jurisdiction where this Policy was issued.

- Your failure to pay premiums as required herein. If you fail to pay premiums as they become due, Aetna may terminate this Policy as of the last day of the Grace Period. Nevertheless, Aetna will terminate this Policy only upon first giving you a written Notice of Cancellation at least fifteen (15) days prior to that termination. The Notice of Cancellation shall state that your Policy will not be terminated if you make appropriate payment in full within fifteen (15) days after Aetna issues the Notice of Cancellation. You are not entitled to a Grace Period until you have made your first payment to Aetna. If you incur charges for Covered Medical Expenses during the Grace Period, coverage will be provided, however, we will deduct the premium payments due from any benefits paid.

- Immediately, upon finding a material misrepresentation by the Member in applying for or obtaining coverage of benefits under this Policy; or finding that the Member has committed fraud against Aetna. This may include, but is not limited to, giving incorrect or misleading information to Aetna, or allowing or assisting a Member other than the Member named on the identification card to make claim for Covered Medical Expenses. Aetna may, at its discretion, terminate a Member's coverage on and after the date that such misrepresentation or fraud occurred. It may also recover from the Member the reasonable and recognized charges for Covered Medical Expenses. In the absence of fraud or material misrepresentation, all statements made by any Member or any Member applying for coverage under this Policy will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the Member, and a copy of same has been furnished to the Member prior to termination.

- Upon return or dishonor by the bank of the third check for payment of premium charges in any twelve 12month period for any reason.

- The occurrence of any other event permitting termination, cancellation or nonrenewal.

- On the first of the month following Aetna's receipt of your written request to cancel.

- Upon becoming ineligible for this coverage. See the section, Notice of Change in Eligibility, in the section ELIGIBILITY.

- A "domestic partner" will no longer be considered to be a defined dependent on the date of termination of the domestic partnership. In that event, you should provide Aetna with a copy of a judgment of termination of domestic partnership.

Grace Period

A Grace Period of 31 days will be granted for the payment of each premium due after the initial premium. The Policy will stay in force during the Grace Period.

Extension of coverage after termination

If you are confined in a hospital or skilled nursing facility on the date your coverage is cancelled upon written notice (except for the reasons described above), benefits will continue until whichever of the following occurs first:

- The date of discharge from the hospital or skilled nursing facility, or
- Care or treatment is no longer medically Necessary, or
- The maximum benefits have been furnished.

Obligations upon termination

Termination of coverage shall not relieve the Member from any obligation incurred prior to the date of termination of this Policy.

Aetna will have no further liability or responsibility under this Policy except for coverage for Covered Medical Expenses provided prior to the date of termination of the Member's coverage.

Any written notice will be officially given by Aetna when it is mailed to your address as it appears on Aetna's records.

You should address any written notice to us at Aetna Life Insurance Company at the address indicated on your Identification Card.

Effect of Benefits Under Other Plans

Non-Duplication of Aetna Benefits

If, while covered under this Policy, you are also covered by another Aetna individual coverage plan:

- You will be entitled only to the benefits of the plan with the greater benefits, and

- Aetna will refund any premium charges received under the plan with the lesser benefits, covering the tie period, both plans were in effect. However, any claims payments made by Aetna under the plan with the lesser benefits will be deducted from any such refund of premium.

If while covered under this Policy, you are also covered under an Aetna group plan:

- You will be entitled only to the benefits of the group plan.

- We will refund any premiums received under the individual plan covering the period both plans were in effect. However, any claims payments made by Aetna under the individual plan will be deducted from any such refund of premiums.

Other Insurance Coverage

Insurance With Other Insurers: If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for the proportion of the loss as the amount which would otherwise have been payable under this policy plus the total of the like amounts under all the other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for the loss, and for the return of the portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of the other coverage shall be taken as the amount which the services rendered would have cost in the absence of the coverage.

Responsibility of Members

- Members or applicants shall complete and submit to Aetna such application or other forms or statements as Aetna may reasonably request. Members represent that all information contained in such applications, forms and statements submitted to Aetna incident to application for this Policy or administration thereunder shall be true; correct; and complete to the best of the Member’s knowledge and belief.

- The Member shall notify Aetna immediately of any change of address for the Member or any of the Member's Covered Dependents.

- The Member understands that Aetna is acting in reliance upon all information provided to it by the Member at time of application and afterwards. The Member represents that information so provided is true and accurate.

- By applying for coverage under this Policy, or accepting its benefits, the Policyholder and all Members who are legally capable of contracting, and the legal representatives of all Members who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions of the Policy.

- Members are subject to and shall abide by the rules and regulations of each Provider from which benefits are provided.

Your duty to notify us

You are responsible to notify us of any the events stated above which would result in termination of the coverage under the Policy or a covered person.

If we accept premium for any covered Member extending beyond the date, age, or event specified in this provision as a reason for termination, then coverage for the covered person will continue during the period for which an identifiable premium was accepted, except where such acceptance of premium was based on misstatement of age.

If you fail to provide timely notification of these events, the termination date and the period for which premium refund (if any) will be calculated will be determined based on when we should have received the notification, as determined by us.

General Provisions

Consideration
This Policy is issued in consideration of the application and payment of the required premiums.

Successor Policyholder
If the Policyholder ceases to be the insured other than by termination of the Policy, the Policyholder's spouse, if any, will become the Policyholder. If at the end of a Premium Period there is no policyholder, this Policy will terminate.

Entire Contract – Changes
The Policy, application for coverage, Summary of Coverage and attachments are the whole contract. Any change in this Policy must be approved by an Aetna executive officer. Such approval must be endorsed or attached to this Policy. No agent can change this Policy or waive any of its terms.

Benefits Not Transferable
You and your Covered Dependents are the only persons entitled to receive benefits under this Policy. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF COVERAGE UNDER THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

Conformity with Law
Any provisions of this Policy which, on its effective date, is in conflict with any applicable statute, regulations or other law is hereby amended to conform with the minimum requirements of such law.

Time Limit on Certain Defenses
After two years from the date a covered person's coverage first became effective under this Policy, no misstatements, except fraudulent misstatements made by the applicant in applying for coverage under this Policy as to such covered person will be used to void the policy or to deny a claim for loss incurred after the end of such two year period.

Legal Action
No legal action will be brought to recover under any benefit on this Policy sooner than 60 days after the required proof of claim has been furnished. No legal action can be brought to recover under any benefit after 3 years from the deadline for

filing claims. If this limit of 3 years is, on the Effective Date of the Policy, less than that allowed by the law of the state in which the Policyholder then lives, such limit is increased to the shortest period allowed by law.

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

Notice
Aetna will meet any notice requirements by mailing the Notice to you at the address listed on our records. You will meet any notice requirements by mailing the notice to: Aetna Life Insurance Company at the address indicated on your Identification Card.

Reporting of Claims or Submission
A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Claim forms will be furnished.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

Notice of Claim
Written notice of claim must be given to Aetna within 30 days after a Covered Medical Expense is incurred, or as soon as reasonably possible. Notice given by or for the Policyholder to Aetna at Hartford, Connecticut, or to an authorized Aetna agent identifying the Policyholder, will be considered notice.

Payment of Benefits
Benefits will be paid as soon as the necessary written proof to support the claim is received. All 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.

Any unpaid balance will be paid immediately upon receipt by Aetna of due written proof

Receipt of Information
We are entitled to receive from any provider of service information about you which is necessary to administer claims on your behalf. By submitting an application for coverage, you have authorized every provider who has furnished or is furnishing care to disclose all facts, opinion or other information pertaining to your care, treatment, and physical conditions, upon our request. You agree to assist in obtaining this information if needed. Failure to assist us in obtaining the necessary information when requested may result in the delay or rejection of your claims until the necessary information is received.

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

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

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

Relationship of Parties
Aetna is not responsible for any claim for damages or injuries suffered by the Member while receiving care from any Preferred Care or any other Provider.

Terms of Coverage
In order for you to be entitled to benefits under this Policy your coverage under this Policy must be in effect on the date you incur a charge for the service or supply.

This Policy, including all terms, benefits, conditions, limitations and exclusions, are subject to the sections TERMS & TERMINATION and ENTIRE CONTRACT - CHANGES.

The benefits to which you may be entitled will depend on the terms of coverage on the date you incur a charge for the service or supply.

Type of Coverage
Any coverage for charges for services and supplies is provided only if they are furnished to a Member while covered.

This Policy does not take the place of or affect any requirement for, or coverage by, workers' compensation insurance.

Change of Residence
If the Policyholder moves to a jurisdiction outside of the State of California, Aetna will, as of the beginning of the Premium Period in which the change occurs, terminate this Policy. Aetna will then issue to the Policyholder (without lapse in coverage) a policy suitable to the jurisdiction where the Policyholder then lives, if Aetna is authorized to issue the policy in that Jurisdiction. The premium for the new Policy will be based upon the premium rates for jurisdiction where the Policyholder's now resides, and the then ages of the covered persons.

If the Policyholder moves within the State of California, it is his or her responsibility to notify us. Premium rates will be adjusted, if necessary, to adjust the Policyholder's new address and the current ages of the covered person, effective at the beginning of the Premium Period following the change of residence.

Currency
All premiums payable under this Policy will be in lawful United States money. All references in this Policy to dollars and cents mean dollars and cents of lawful United States money.

Physical Examination
Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom claim is made or certification of benefits have been requested. This will be done at all reasonable times while the certification or a claim for benefits is pending or under review. This will be done at Aetna's expense.

Assignment
Coverage may be assigned only with Aetna's written consent.

Conversion
(Note: This section does NOT continue insurance coverage under this Policy. It provides for issue of another Policy).

If a covered person's insurance under this Policy (other than the Policyholder's) terminates for one of the reasons as stated in the "Termination of Coverage" section such person may obtain from Aetna an insurance policy of a kind then being issued by Aetna for conversion (referred below as the "policy") which Aetna may refuse to renew under certain conditions. No medical exam is required. Written application for the converted policy must be made and the first premium paid to Aetna within 31 days after the termination.

Except as otherwise stated, the form of the policy will be such as is then offered by Aetna for conversion. The policy will not violate any law or regulation. Aetna, on request, will give details of the policy.

The policy may reduce its benefits by any continued benefits paid under this Policy.

Aetna need not issue the policy to a person who will, at the date of conversion, be covered for like benefits by another policy of hospital or surgical expense insurance, hospital service or medical expense indemnity corporation subscriber contract or any group contract, benefit required by a law, or welfare plan which would result in over-insurance by Aetna's standard then current where the policy would be delivered.

The policy may permit Aetna to ask at a premium due date if a covered person is then covered for like benefits by another policy as stated in the preceding paragraph. If a person is so covered and fails to give details, the benefits paid under the policy may be based on the actual expenses less expenses paid by such other coverage.

Aetna may decline to:

- Issue the policy if application is not made in a place where Aetna is authorized to issue it.
- Cover a person for any benefit in the policy, if such benefit is not legal.

The first Premium for the policy will be Aetna's then usual rate for the applicant's class of risk, and the age of each insured person.

The policy will take effect on the day after this insurance terminates.

Glossary

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

Attained Age
Is the Member's age at the time of each premium billing.

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

Calendar Year
This is a twelve-month period starting each January 1 at 12:01 a.m. local Time.

Companion
This is a Member whose presence as a Companion or caregiver is necessary to enable a National Medical Excellence Program Patient:

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

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

Cosmetic Surgery
Is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. Reconstructive Surgery is surgery that is medically Necessary and appropriate that is performed to correct or repair abnormal structures of the body caused by congenital defects; developmental abnormalities; trauma; infection; tumors; or disease to do either of the following: to improve function; or to create a normal appearance; to the extent possible.
Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Custodial Care

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

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

Deductible

The amount of charges you must pay for any Covered Medical Expenses and Prescription Drugs before any benefits are payable to you under this Policy. Your Calendar Year deductibles are stated in the Summary of Coverage.

Dentist

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

Directory

This is a listing of all Preferred Care Providers for your class of which you are a member. Copies of this Directory will be furnished to you. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at www.aetna.com.

Durable Medical and Surgical Equipment

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

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

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

Emergency Admission

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

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
  - placing the Member's health in serious jeopardy; or
  - serious impairment to bodily function; or
  - serious dysfunction of a body part or organ; or
  - in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care

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

- placing the Member's health in serious jeopardy; or
- serious impairment to bodily function; or

- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

In the case of Emergency Care, you, the Member's physician or the hospital must call the number shown on your ID card to obtain certification for the emergency admission.

It is important to call no later than 48 hours following the start of a confinement as a full-time inpatient which requires an emergency admission, unless it is not possible to request certification within that time. In that case, it must be done as soon as reasonably possible.

If in the opinion of the Member's physician, it is necessary for the Member to be confined for a longer time than already certified, you must call the number shown on your ID card to certify more days of confinement. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent to the hospital or treatment facility. A copy will be sent to you and to the physician.

Emergency Condition

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

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

Experimental / Investigational Procedures

Mean any medical, surgical, and/or other procedures, services, products, drugs or devices (including implants) is considered experimental or investigational if:

- its use is mainly limited to laboratory and/or research; or
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows it is the subject of ongoing phase I or II clinical trials or under study to determine if maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the state or means of treatment or diagnosis; or
- reliable evidence shows that the consensus of the opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated doses, its toxicity, its safety, its efficacy or its efficacy as compared with the stated means of treatment of diagnosis; or
- reliable evidence shows that it is not generally approved or used by physicians in the medical community; or
- it does not have final approval from the appropriate governmental regulatory body.

Full Time Student

A student who is enrolled at an accredited college, university or trade school participating in the Federally Guaranteed Student Loan Program and who is attending classes, carrying at least 12 units per term.

Home Health Care Agency

This is an agency that:

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

- meets licensing standards according to state and local laws to provide skilled nursing and other services on a visiting basis in the Member's home.
- must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Hospice Facility

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

- Mainly provides inpatient Hospice Care to terminally ill Members.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians; at least one such physician must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a R.N.
- Has a full-time administrator.
- Is Medicare certified.

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **Physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **Hospital** and is accredited as a **Hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **Hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **Skilled Nursing Facility**, hospice, rehabilitative **Hospital** or facility primarily for rehabilitative or custodial services.

Institute of Excellence (IOE)

A hospital or other facility that has contracted with Aetna to furnish services or supplies to an IOE in connection with specific transplant procedures at a negotiated charge. A facility is an IOE facility only for those types of transplants, procedures for which it has signed a contract.

Member

The term “Member” shall mean the Policyholder and/or a Dependent.

Necessary

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

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the Member's overall health condition;
- be a diagnostic procedure, indicated by the health status of the Member and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the Member's overall health condition; and

- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

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

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

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

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

Negotiated Charge

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

Non-Occupational Disease

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

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

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

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

Non-Occupational Injury

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

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

Non-urgent Admission

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

Orthodontic Treatment

This is any:

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

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

- of the teeth; or

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

whether or not for the purpose of relieving pain.

Not included is:

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

Pharmacy
An establishment where prescription drugs are legally dispensed.

Physician
This means a legally qualified physician. Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician.

Pre-existing Condition
This means an illness, injury, disease or physical condition for which medical advice, diagnosis, care or treatment, including the use of prescription drugs was recommended or received from a physician during the six (6) months immediately preceding the Member's effective date of coverage.

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

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

Preferred Participating Hospital is a Hospital that has entered into an Agreement with Aetna. A list of these Preferred Participating Hospitals is available upon request from our Customer Service Representatives.

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

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

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

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

Prescription Drug and Supplies
Any of the following:

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

- Disposable diabetic supplies.

Psychiatric Physician

This is a physician who:

- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

Recognized Charge

Only that part of a charge for **Non-Preferred Care** which is recognized is covered.

As to facility charges, the recognized charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it;
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge established in Aetna's Allowable Fee Schedule.

As to other charges, the recognized charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it;
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the **negotiated charge** that would apply if such services or supplies were received from a **Preferred Care Provider**.

As to other charges, 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.

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.

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.

R.N.

This means a registered nurse.

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 a **R.N**., or by a **L.P.N**. directed by a full-time **R.N**.; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental disorder**s or **severe biologically-based mental illnesses**.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law**.**
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons**.**
- Qualifies as a **Skilled Nursing Facility** under Medicare or as an institution accredited by**:**
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of **Hospital**s of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities.

Surgery Center

This is a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
- physicians who practice surgery in an area hospital; and
- dentists who perform oral surgery.
- Has at least two operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
- a physician trained in cardiopulmonary resuscitation; and
- a defibrillator; and
- a tracheotomy set; and
- a blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.

- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

Treatment Facility (Severe Mental Illness)

This is an institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of severe mental illnesses.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist 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 care 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.

Urgent Admission

One where the physician admits the Member to the hospital due to:

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

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

Urgent Condition

This means a sudden illness; injury or condition that:

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

Utilization and Pre-service Review Procedures

Procedures established by Aetna to determine whether certain admissions, procedures, surgeries, prescription drugs or services are medically necessary and are the appropriate length of stay, if applicable.

Us/We

Aetna Life Insurance Company.

Privacy Notice

The information in this Notice is not a part of the Policy. It is important to you as a covered Member under the Policy. We have bound it into this document only as an aid to you in keeping insurance related material together.

This Notice describes certain aspects of Aetna's insurance privacy policy which apply to you as a covered Member in a policy of insurance issued by Aetna. This does not apply where a different approach is required by law.

Information Which May be Collected

Aetna, in providing insurance services to you, relies mainly on the information you give on your application form and when you file claims.

Aetna may also collect information about you from other sources. This is information necessary for Aetna to perform its function with regard to the insurance transaction in question.

Disclosure of Information To Others

All of this information will be treated as confidential. It will not be disclosed to others without your authorization, except in some instances where such disclosure is necessary for the conduct of Aetna's business. Disclosure cannot be contrary to any law which applies.

The following sets forth the types of disclosure that may be made:

- Information may be disclosed to other insurers if there may be duplicate coverage or a need to preserve the continuity of your coverage.
- Information may be disclosed to Peer Review Organizations and other agencies to determine whether health services were necessary and reasonably priced.

Your right of access and correction.

In addition, information may be given to regulators of Aetna's business and to others as may be required by law. It may also be given to law enforcement authorities when needed to prevent or prosecute fraud or other illegal activities.

In general, you have a right to learn the nature and substance of any information Aetna has in its files about you. You may also have a right of access to such files, except information which relates to a claim or a civil or criminal proceeding, and to ask for correction, amendment, or deletion of Member information. This can be done in states which provide such rights and which grant immunity to insurers providing such access. If you request any health information, Aetna may elect to disclose details of the information you request to your (attending) physician. If you wish to exercise this right or if you wish to have more detail on our information practices, please contact:

Aetna Life Insurance Company
Executive Response Team, MCAF
151 Farmington Avenue
Hartford, Connecticut 06156