

Aetna Health Savings Account Addendum – Effective January 1, 2016

Addendum to the Aetna H S A Summary Plan Description (SPD).

Effective January 1, 2016

The IRS has increased the Family Contribution Maximum for 2016:

Individual: \$3,350 (not changing)

Family: \$6,650 to \$6,750

(EE's age 55 and older can contribution an additional \$1000-not changing)

The plan includes all of the preventive care benefits mandated by the ACA (No longer Grandfathered).

Preventive Care Covered at 100% In-network

Routine Physical Exams	Family Planning – Tubal Ligation
Obesity Preventive Counseling	Lactation Consultation
Tobacco Preventive Counseling	Contraceptive drugs and devices (except those covered by RX plan) including associated office visit (i.e. IUDs).
Alcohol/Drug Abuse Counseling	Breast Pumps and supplies
Preventive Lung Cancer Screening Colorectal Cancer Screening (ie colonoscopy) Routine PSA and DRE	Contraceptive Consultation
Routine GYN and Pap	Routine eye exam (includes pediatric) is covered at 100% every (instead of every year).
Routine mammography	Prenatal care covered at 100% (delivery & nursery care remain covered at 90%).
Breast Pumps and supplies	OptumRx Prescription Drug Plan covers: Oral Contraceptives, barrier methods, OTC contraceptives, Plan B and ella (prescription required).
Pre-natal maternity office visits	OptumRx Prescription Drug Plan covers: Aspirin products, iron supplements, Vitamin D, Folic Acid & Prenatal Vitamins with prescription.

The Prescription Drug Plan is changing from Express Scripts (ESI) to OptumRx

This is only a brief summary of the Plan Features. Please refer to the Summary of Benefits and Plan Booklet for a complete description.

- The copays are not changing and remain \$5/\$30/\$50 after deductible for retail and \$10/\$60/\$90 after deductible Home Delivery in-network (except for preventive meds).
- The drug formulary is changing
- Some medications are excluded
- Home Delivery of maintenance medications/specialty medications can be delivered to your home address or new for 2016, you can direct the delivery to Gannett Health Center Pharmacy on the Ithaca campus.
- Briova is the specialty pharmacy replacing ESI's Accredo
- Aspirin products, iron supplements, Vitamin D, Folic Acid & Prenatal Vitamins with prescription covered at \$0 copay (in-network)

Effective April 1, 2015

Documentation Requirements Effective 4/1/15-copies only

Employee: Social Security Card (or ITIN-Individual Taxpayer Identification Number for non-US Citizens).

You must provide copies of documents to support your dependent's eligibility for coverage.

Spouse or Domestic Partner: Birth Certificate (or Visa/Passport accepted for non-US citizens), Social Security Card (or ITIN-Individual Taxpayer Identification Number for non-US citizens), Marriage Certificate, Domestic Partner Statement

Children (biological), stepchild, adopted: Birth Certificate (or Visa/Passport accepted for non-US citizens), Social Security Card, ITIN (Individual Taxpayer Identification Number) for non-US citizens, Proof of Disability, if applicable, Documentation establishing Paternity by Court Order acknowledging Paternity. If your child is neither of the above, you must also complete the Special Dependent Enrollment Form.

Effective January 1, 2015

Express Scripts Prescription Drug Plan Changes

Preferred Retail Pharmacy Network

You pay deductible, then a \$5/\$30/\$50 copay at retail for up to a 30 day supply if you use pharmacies participating in the Preferred Retail Pharmacy Network. Pharmacies include: Kinney, Rite Aid, Target, Walmart, Wegmans, Quilans, Green Street Pharmacy, Gannett Student Health Center,

You pay deductible then \$15/\$40/\$60, if you use CVS/Walgreens (Duane Reed), pharmacies not participating.

Exclusionary Formulary: Certain medications that are available as generics or on the formulary are no longer covered as of 1/1/15. Members can appeal and ESI will review the clinical information provided by the physician.

Social Security's Definition of a "Spouse".

As of January 1, 2015, the Social Security's definition of "spouse" has expanded to include a same-sex spouse for the purpose of determining Medicare primacy. Therefore, an active employee's same-sex spouse, age 65 or older, will be Aetna primary not Medicare primary.

H S A contribution limit changing for January 1, 2015:

Individual: \$3,300 to \$3,350

Family: \$6,550 to \$6,650

(Employee age 55 and over can contribute up to an additional \$1000).

This includes Cornell's \$1,000 annual contribution (or if enrolling after open enrollment, it is pro-rated).

Deductible and OOP maximum changing for 2015:

Deductible:

Individual: \$1,250 to \$1,500 (out of network: \$2,500 to \$3,000)

Family: \$2,500 to \$3000 (out of network: \$5,000 to \$6,000)

Out of Pocket Max:

Individual: \$3,000 to \$3,250 (out of network: \$4,000 to \$4,250)

Family: \$5,000 to \$5,500 (out of network: \$7,000 to \$7,500)

Certificates of Creditable Coverage (HIPAA Certs) No Longer Required

The Affordable Care Act prohibits the use of pre-existing condition clauses resulting in the need to provide certificates of creditable coverage no longer necessary. On February 24, 2014, the Treasury, the Department of Labor, and the Department of Health and Human Service jointly issued final regulations which eliminated the requirement for plan sponsors to issue the certificates after 12/31/14.

Grandfathered Health Plan Notice for January 1, 2015

Cornell University believes your plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your employer or Aetna member services using the phone number on your member id card.

If your plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [HUwww.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)UH. This website has a table summarizing which protections do and do not apply to grandfathered health plans. If your plan is a nonfederal governmental plan, you may also contact the U.S. Department of Health and Human Services at [HUwww.healthreform.gov](http://www.healthreform.gov)UH.

H S A contribution limit changing for January 1, 2014:

Individual from \$3250 to \$3300

Family from \$6450 to \$6550

This includes Cornell's \$1,000 annual contribution (or if enrolling after open enrollment, it is pro-rated).

Effective August 29, 2013

On August, 29, 2013, the Internal Revenue released new federal tax guidelines for same-sex spouses. This is due to the Supreme Court's ruling in *United States v. Windsor* that the Defense of Marriage Act (DOMA) provision prohibiting the recognition of same-sex marriages for federal law purposes was unconstitutional. The IRS determined that same-sex couples, legally married in jurisdictions that recognize their marriages, will be treated as married for federal tax purposes regardless of whether the couple lives in a jurisdiction that recognizes same-sex marriage. This means that if a same-sex couple is married in a state that recognizes same-sex marriage and moves to a state that does not recognize same-sex marriage, then he or she will still be considered married for federal tax purposes.

Effective July 1, 2013

Autism Spectrum Disorder

Autism and other pervasive developmental disorders will now be covered the same as any other expense based on the type and place of service. Coverage will include applied behavioral analysis (ABA) and behavioral therapy as well as mental health therapy and testing services.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual Deductible	\$1,250	\$2,500
Family Deductible	\$2,500	\$5,000

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Physician Services</i>		
<i>Office Visits</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Outpatient Treatment Of Mental Disorders</i>		
<i>Outpatient Services</i>	90% per visit after Calendar Year deductible	80% per visit after the Calendar Year deductible
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Outpatient Physical, Occupational and Speech Therapy combined</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Maximum Visit Limit per <i>Calendar Year</i> for Speech Therapy only	50 visits	50 visits

Generally it includes the following primary services:

- Evaluation and treatment by a speech-language pathologist
- Audiological hearing evaluation
- Medical evaluation
- Behavior modification
- Intensive education interventions
- Medical therapy or psychotherapy

You must call to Precertify psychological testing, neuropsychological testing and applied behavioral analysis.

Not all services are covered. Aetna considers the following procedures and services experimental and investigational because the peer-reviewed medical literature does not support the use of these procedures and services in the assessment and treatment of autism and other pervasive developmental disorders:

Assessment:

1. Allergy testing (including food allergy for gluten, casein, candida, and other molds; allergen specific IgG and IgE)
2. Electronystagmography (in the absence of dizziness, vertigo, or balance disorder)
3. Erythrocyte glutathione peroxidase studies
4. Event-related brain potentials
5. Hair analysis for trace elements (see [CPB 0300 - Hair Analysis](#))
6. Intestinal permeability studies
7. Magnetoencephalography/magnetic source imaging (see [CPB 0279 - Magnetic Source Imaging/Magnetoencephalography](#))
8. Neuroimaging studies such as CT, functional MRI (fMRI), MRI, MRS (see [CPB 0202 - Magnetic Resonance Spectroscopy \(MRS\)](#)), PET (see [CPB 0071 - Positron Emission Tomography \(PET\)](#)), and SPECT (see [CPB 0376 - Single Photon Emission Computed Tomography \(SPECT\)](#))
9. Nutritional testing (e.g., testing for arabinose and tartaric acid)
10. Provocative chelation tests for mercury
11. Stool analysis
12. Tests for celiac antibodies
13. Tests for homocysteine (see [CPB 0763 - Homocysteine Testing](#))
14. Tests for immunologic or neurochemical abnormalities
15. Tests for micronutrients such as vitamin levels
16. Tests for mitochondrial disorders including lactate and pyruvate
17. Tests for thyroid function
18. Tests for urinary peptides
19. Tests for amino acids (except quantitative plasma amino acid assays to detect phenylketonuria), fatty acids (non-esterified), organic acids, citrate, silica, urine vanillylmandelic acid
20. Tests for heavy metals (e.g., antimony, arsenic, barium, beryllium, bismuth, mercury)
21. Tests for trace metals (e.g., aluminum, cadmium, chromium, copper, iron, lead, lithium, magnesium, manganese, nickel, selenium, zinc)
22. Tympanometry (in the absence of hearing loss).

Treatment

1. Acupuncture
2. Anti-fungal medications (e.g., fluconazole, ketoconazole, metronidazole, nystatin)
3. Anti-viral medications (e.g., acyclovir, amantadine, famciclovir, isoprinosine, oseltamivir, valacyclovir)
4. Auditory integration training (auditory integration therapy) (see [CPB 0256 - Sensory and Auditory Integration Therapy](#))
5. Chelation Therapy (see [CPB 0234 - Chelation Therapy](#))
6. Cognitive rehabilitation (see [CPB 0214 - Cognitive Rehabilitation](#))

7. Elimination diets (e.g., gluten and milk elimination)
8. Facilitated communication
9. Herbal remedies (e.g., astragalus, berberis, echinacea, garlic, plant tannins, uva ursi)
10. Floor time therapy
11. Holding therapy
12. Immune globulin infusion
13. Manipulative therapies
14. Massage therapy
15. Music therapy and rhythmic entrainment interventions
16. Neurofeedback/EEG biofeedback (see [CPB 0132 - Biofeedback](#))
17. Nutritional supplements (e.g., dimethylglycine, glutathione, magnesium, megavitamins, omega-3 fatty acids, and high-dose pyridoxine)
18. Secretin infusion
19. Sensory integration therapy (see [CPB 0256 - Sensory and Auditory Integration Therapy](#))
20. Stem cell transplantation
21. Systemic hyperbaric oxygen therapy (see [CPB 0172 - Hyperbaric Oxygen Therapy \(HBOT\)](#))
22. Tomatis sound therapy
23. Vision therapy (see [CPB 0489 - Vision Therapy](#))
24. Vitamins and minerals (calcium, germanium, magnesium, manganese, selenium, tin, tungsten, vanadium, zinc, etc.).
25. Weighted blankets/vests.

Please refer to Aetna's Clinical Policy Bulletin for a more complete list of covered services and any applicable exclusions: http://www.aetna.com/cpb/medical/data/600_699/0648.html.

Transgender Health

Transgender, transsexual and gender nonconforming disorders will now be covered the same as any other expense based on the type and place of service. Coverage will include therapy and certain medical procedures related to gender identity confirmation procedures.

Generally it includes the following primary services:

- Medically necessary core surgical procedures for female to male persons include: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty and placement of testicular prostheses, and erectile prostheses.
- Medically necessary core surgical procedures for male to female persons include: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty.

Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic and not covered. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic and not covered.

Please refer to Aetna’s Clinical Policy Bulletin for a more complete list of covered services and any applicable exclusions: http://www.aetna.com/cpb/medical/data/600_699/0615.html.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$1,250	\$2,500
Family Deductible*	\$2,500	\$5,000

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
<i>Office Visits</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Outpatient Treatment Of Mental Disorders		
<i>Outpatient Services</i>	90% per visit after Calendar Year deductible	80% per visit after the Calendar Year deductible
Short Term Outpatient Rehabilitation Therapies		
<i>Outpatient Physical, Occupational and Speech Therapy combined</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Maximum Visit Limit per <i>Calendar Year</i> for Speech Therapy only	50 visits	50 visits
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Surgery		
<i>Performed in a Hospital</i>	90% per visit/surgical procedure after Calendar Year deductible	80% per visit/surgical procedure after Calendar Year deductible
<i>Performed in a Physician’s Office</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

You can find a participating provider through Aetna’s DocFind Site:

- <http://www.aetna.com/docfind>
- Select Directories and Resources on the left hand side of the page
- Click on GLTB provider resources
- From there, a disclaimer will pop up saying you are leaving the Aetna site and redirected to the GLTB site where you can go to “Resources” on the top of the page, then select “For Patients” and “Find a provider”. If you encounter any problems accessing the site from DocFind, you can get there directly via www.glma.org.
- Once you have selected the applicable provider, you will need to return to the Aetna DocFind to confirm if they are a participating provider in Aetna’s network.

You can also call Aetna's Member Services at 877-371-2007, if you need assistance.

Effect of Medicare

Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.

Clarification for 1/1/13: This will also be done and regardless if the provider accepts Medicare assignment, if the provider does not accept Medicare assignment or if the provider opts-out of Medicare.

Business Travel Abroad Coverage

Faculty and staff travelling abroad on university business can access help for medical attention through Aetna International, a unit that specializes in corporate travel. This is a rider to the Endowed Health Plans that uses an established network of local medical providers in over 160 countries, pays for care in local currency and virtually eliminates the need to pre-pay bills and seek reimbursement upon returning to the USA. Aetna International is fully insured rider which does not allow coverage for individuals age 70 and older, which is a concern for an academic institution. However, the CPHL plan continues to accept the liability for medically necessary treatment regardless of where that care is delivered and regardless of age.

For more information, please refer to our website

https://www.hr.cornell.edu/benefits/health/new_coverage.html#international

Plan Changes Effective 1/1/2013

Express Scripts/Medco Prescription Drug Plan

The Retail Refill Allowance (RRA) provision of the ES/Medco Prescription Drug Plan is eliminated.

Health Savings Account

The individual contribution is increasing from \$3,100 to \$3,250

The family contribution is increasing from \$6,250 to \$6,450

This includes the amount Cornell contributes of \$1,000, spread out over your annual paycycle for current employees.

The deductible for the Aetna H S A is increasing for 2013:

Individual: from \$1,200 to **\$1,250** in-network (\$2,400/\$2,500 out of network)

Family: from \$2,400 to **\$2,500** in-network (\$4,800/\$5,000 out of network)

Payflex will administer the Aetna Health Savings Account

High Deductible Health Plan Changes Effective 1/1/2011

Office Visit copay is changing from \$18 to \$20

Health Savings Account

The individual contribution is increasing from \$3,050 to \$3,100

The family contribution is increasing from \$6,150 to \$6,250

(These amounts include Cornell's contribution)

Same-Sex Partner coverage is changing to Domestic Partner coverage to include unmarried opposite sex partners. A Domestic Partnership Statement must be completed. Please refer to <http://hr.cornell.edu/benefits/partners.html> for more information.

Spouses of the same-sex married in New York State as well as the following jurisdictions: Connecticut, Iowa, Mass., New Hampshire, Vermont, Washington, DC and countries: The Netherlands, Belgium, Spain, Canada, South Africa, Norway, Sweden, Portugal, Iceland and Argentina, need only to provide a valid and current marriage certificate in order to enroll their spouse for health benefits. Please refer to <http://hr.cornell.edu/benefits/partners.html> for more information.

Office Visit Copay is changing from \$18 to \$20

Medco Prescription Drug Copays Increasing (Except Generics)

Retail copays changing from \$5/\$25/\$45 to \$5/\$30/\$50

Mail Order copays changing from \$10/\$50/\$75 to \$10/\$60/\$90

High Deductible Health Plan Changes Effective 1/1/2011

Office Visit copay is changing from \$15 to \$18

Medco Retail Refill Allowance

Aetna H S A Addendum 1.1.16

If a member continues to use the retail pharmacy instead of Medco By Mail to purchase maintenance medications, the member will pay a higher copay on the 4th refill for up to a 30 day supply. The copay will be \$5/\$40/\$65 (no change for generics) at retail instead of \$5/25/\$45.

Health Savings Account

- Cornell's contribution will increase from \$500 to \$1,000 annually.
- The IRS penalty for using the Health Savings Account funds for non-qualified expenses will increase from 10% to 20%. Refer to your secure Aetna member website (www.aetna.com) for a list of qualified Health Savings Account expenses or visit the IRS website at www.irs.gov and select "Forms and Publications" to review Publication 502.
- Over-the-Counter (OTC) medications require a doctor's prescription, if you plan to use the Health Savings Account to pay for OTC medications. You will not need a prescription to use your Health Savings Account for other eligible OTC items like contact lens solutions and bandages.

Mental Health Treatment

The Plan covers medically necessary counseling services provided by a qualified provider while you are participating in a Wilderness Program provided you submit an itemized bill outlining the counseling services provided by a qualified mental health provider. A Wilderness Program does not otherwise meet the Plan's requirements to be considered a residential treatment facility, therefore, room and board and other supplies provided during a stay are not covered. This information revises the information on Page 39 of the Booklet.

Aetna Claims, Appeals and External Review

Filing Health Claims under the Plan

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims, Appeals and External Review section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (Aetna). The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Urgent Care Claims

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

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 24 hours after the claim is received.

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

Other Claims (Pre-Service and Post-Service)

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

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

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

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

Ongoing Course of Treatment

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

Health Claims – Standard Appeals

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational**; or
- A decision that the service or supply is not **medically necessary**.

A “Final Internal Adverse Benefit Determination” is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan’s appeal requirements (“Deemed Exhaustion”) and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

Full and Fair Review of Claim Determinations and Appeals

Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna’s Member Services Unit at the toll-free phone number on the back of your ID card (also listed at the end of this booklet). Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

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

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

Health Claims – Voluntary Appeals

External Review

“External Review” is a review of an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A “Final External Review Decision” is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

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

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

Request for External Review

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law; or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO

Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- (i) Your medical records;
- (ii) The attending health care professional's recommendation;
- (iii) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- (iv) The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- (v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- (vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- (vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan must allow you to request an expedited External Review at the time you receive:

- (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize
- (b) your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- (c) A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

High Deductible Health Plan Changes Effective 9/1/2010:

Coverage for Dependent Children

Children between the ages of 19 and 26 are eligible to be covered under your plan. Children may be added regardless of their status. It does not matter if they are full time students, married, live at home or not, work for an employer that offers health insurance or are not your tax dependent. **IMPORTANT: The tax law did not change. You could have under your health plan a dependent adult who is not a dependent for tax purposes. That means you'll pay a penalty plus taxes if you use the pretax dollars from your HSA to pay health expenses for your older covered dependent. You can call Aetna at 1-877-371-2007 if you have questions regarding this provision of the tax law.**

Cornell will cover your child until December 31 of the year in which he or she reaches age 26.

High Deductible Health Plan Changes Effective 1/1/2010

- Copays are changing from \$12 to \$15
- Prescription Drug Copays are changing as follows:

Retail copays from \$5/\$20/\$40 to \$5/\$25/\$45 (no change for generic)

Mail: copays from \$10/\$40/\$60 to \$10/\$50/\$75 (no change for generic)

- Deductible :

In-Network individual from \$1,150 to \$1,200; family from \$2,300 to \$2,400

Out-of-Network individual from \$2,300 to \$2,400; family from \$4,600 to \$4,800

- Out of Pocket Maximum (OOP):

In-Network individual from \$2,500 to \$3,000; family from \$4,500 to \$5,000

Out-of-Network individual from \$3,500 to \$4,000; family from \$6,500 to \$7,000

Mental Health Parity Adopted

Recent federal legislation created an obligation for health plans to cover mental health and substance abuse treatment in the same manner as other medically necessary treatment. The endowed health plans for active and retired faculty and staff which include the Health Savings Account Plan, will comply with this new requirement as of January 1, 2010. Medical, surgical or mental health care will be considered for coverage using the same evidence-based criteria for treatment. (Visit Limits for behavioral health benefits have been removed; coinsurance is included as part of the medical plan deductible and OOP).

Schedule of Benefits

Employer: Cornell University
ASC: 397366
Issue Date: May 3, 2010
Effective Date: January 1, 2009
Schedule: 9A
Booklet Base: 9

For: Choice POS II High Deductible Health Plan with a Health Savings Account

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	**OUT-OF-NETWORK
Calendar Year Deductible*		
<u>Employee Only Coverage:</u>		
Individual Deductible*	\$1,150	\$2,300
<u>Employee and Family Coverage:</u>		
Family Deductible*	\$2,300	\$4,600
*Unless otherwise indicated, any applicable Individual and or Family Plan deductible must be met before benefits are paid.		
**.-Subject to Recognized Charge		
Out-of-Pocket Maximum		
<u>Employee Only Coverage:</u>	\$2,500	\$3,500
<u>Employee and Family Coverage:</u>	\$4,500	\$6,500
Out-of-Pocket Maximum includes plan deductible and copayments but excludes precertification penalties.		
<i>Lifetime Maximum Benefit per person</i>	Unlimited	Unlimited

Payment Percentages listed in the Schedule below reflects the Plan Payment Percentage. This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Wellness Benefit		
Routine Physical Exams Adults only. Includes coverage for immunizations.	\$12 exam copay then the plan pays 100%	80% per exam after Calendar Year deductible
Maximum Exams every 2 calendar years		
Adults age 19 to 65	1 exam	1 exam
Maximum Exams per every calendar year		
Adults age 65 and over	1 exam	1 exam
Well Child Exams Includes coverage for immunizations	\$12 exam copay then the plan pays 100%	80% per exam after Calendar Year deductible
Maximum Exams		
Under age 2		
first 12 months of life	7 exams	7 exams
13th-24th months of life	2 exams	2 exams
Maximum Exams per calendar year		
For age 2 to 19	1 exam	1 exam
Routine Gynecological Exam	\$12 exam copay then the plan pays 100%	80% per exam after Calendar Year deductible
Maximum exams per Calendar Year	1 exam	1 exam

<i>Routine Hearing Exam</i> 1 exam every 24 months	\$12 exam copay then the plan pays 100%	80% per exam after Calendar Year deductible
--	--	--

<i>Hearing aids</i> child age 12 and under once every two calendar years adults and children age 13 once every four calendar years \$1,500 max per aid per ear Excludes batteries and repairs	90% after Calendar Year deductible	80% after Calendar Year deductible
--	------------------------------------	------------------------------------

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
---------------	---------	----------------

<i>Routine Cancer Screenings</i>		
---	--	--

<i>Routine Mammography</i> For covered females over.	\$12 test copay then the plan pays 100%	80% per test after Calendar Year deductible
--	--	--

Maximum tests per Calendar Year	1 test	1 test
---------------------------------	--------	--------

<i>Prostate Specific Antigen Test</i> For covered males age 40 and over.	\$12 test copay then the plan pays 100%	80% per test after Calendar Year deductible
--	--	--

Maximum tests per Calendar Year	1 test	1 test
---------------------------------	--------	--------

<i>Routine Digital Rectal Exam</i> For covered males age 40 and over.	\$12 test copay then the plan pays 100%	80% per test after Calendar Year deductible
---	--	--

Maximum tests per Calendar Year	1 test	1 test
---------------------------------	--------	--------

<i>Routine Pap Smears Including Related Lab Fees</i>	\$12 test copay then the plan pays 100%	80% per test after Calendar Year deductible
---	--	--

Maximum tests per Calendar Year	1 test	1 test
---------------------------------	--------	--------

<i>Fecal Occult Blood Test</i>	\$12 test copay then the plan pays 100%	80% per test after Calendar Year deductible
Maximum tests per Calendar Year	1 test	1 test
<i>Sigmoidoscopy</i> Age 50 and over	\$12 test copay then the plan pays 100%	80% per test after Calendar Year deductible
Maximum Tests per 5 consecutive year period	1 test	1 test
<i>Double Contrast Barium Enema (DCBE)</i> Age 50 and over	\$12 test copay then the plan pays 100%	80% per test after Calendar Year deductible
Maximum Tests per 5 consecutive year period	1 test	1 test
<i>Colonoscopy</i> age 50 and over	\$12 test copay then the plan pays 100%	80% per test after Calendar Year deductible
Maximum Tests per 10 consecutive year period	1 test	1 test
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Vision Care</i>		
<i>Eye Examinations</i> including refraction	\$12 exam copay then the plan pays 100%	80% per exam after Calendar Year deductible
Maximum Benefit per every two calendar years	1 exam	1 exam
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Physician Services</i>		
<i>Office Visits to Primary Care Physician</i> Office visits to non-specialist	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Specialist Office Visits</i> <i>All Specialists except those specifically listed in this schedule.</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

<i>Physician Office Visits-Surgery</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Administration of Anesthesia</i>	90% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
<i>Allergy Testing and Treatment</i>	90% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
<i>Allergy Injections</i>	90% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
<i>Immunizations when not part of the physical exam</i>	90% per procedure after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Prenatal Visits</i>	90% per procedure after Calendar Year deductible	80% per visit after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Emergency Medical Services</i>		
<i>Hospital Emergency Facility</i>	90% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible
<i>Non-Emergency Care in a Hospital Emergency Room</i>	50% per procedure after Calendar Year deductible	50% per procedure after Calendar Year deductible

Urgent Care Services		
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	90% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
Non-Urgent Use of Urgent Care Provider <i>(at a non-hospital free standing facility)</i>	Not covered	Not covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Diagnostic and Preoperative Testing <i>(except complex imaging services)</i>	90% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
Complex Imaging Services		
Complex Imaging	90% per test after Calendar Year deductible	80% per test after Calendar Year deductible
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	90% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
Diagnostic X-Rays (except Complex Imaging Services)		
Performed at a Hospital Outpatient Facility	90% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	90% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birth Center	90% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible

<i>Hospital Facility Expenses</i> Room and Board (including maternity)	90% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	90% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
<i>Skilled Nursing Inpatient Facility</i>	90% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Maximum Days per Calendar Year	90 days	90 days
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Specialty Benefits</i>		
<i>Home Health Care</i> <i>(Outpatient)</i>	90% per visit after the Calendar Year deductible	80% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	120 visits	120 visits
<i>Private Duty Nursing</i> <i>(Outpatient)</i>	90% per visit after the Calendar Year deductible	80% per visit after the Calendar Year deductible
Maximum Visit Limit per <i>Calendar</i> <i>Year</i>	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.
<i>Hospice Benefits</i>		
<i>Hospice Care - Facility Expenses</i> (Room & Board)	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
<i>Hospice Care - Other Expenses</i> <i>during a stay</i>	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Maximum Benefit per lifetime	Unlimited	Unlimited
<i>Hospice Outpatient Visits</i>	100% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Maximum Benefit per lifetime	Unlimited	Unlimited

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Infertility Treatment</i>		
<i>Basic Infertility Expenses</i> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Advanced Reproductive Technology (ART) Expenses or Artificially Assisted Fertilization</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
The AAF benefit is a limited provision expressed as a lifetime maximum dollar amount that applies to all endowed health plans one may join over time. The lifetime maximum benefit limit is \$20,000 per household, meaning that the maximum lifetime benefit will not be provided more than once to an employee's household, regardless of how that household may change over time or the number of Cornell employees in the household.	\$20,000	\$20,000

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Mental Disorders</i>		
<i>Mental Disorders</i>	90% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible
Maximum Benefit per Calendar Year	45 days	45 days
<i>Outpatient Treatment Of Mental Disorders</i>		
<i>Mental Disorders</i>	90% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	50 visits	50 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Alcoholism and Substance Abuse</i>		
<i>Inpatient Treatment</i>	90% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible
Maximum Days per Calendar Year	45 days	45 days
<i>Outpatient Treatment</i>		
	90% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	50 visits	50 visits

Important Notice:

Both **network** and **out of network** alcoholism and substance abuse and mental illness treatment expenses accumulate toward any maximum shown above for alcoholism and substance abuse and mental illness treatment expenses.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Obesity Treatment Surgical and Non Surgical</i>		
<i>Outpatient Obesity Treatment (non surgical)</i>	90% per visit after the Calendar Year deductible	80% per visit after the Calendar Year deductible
<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	90% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
<i>Related Outpatient Morbid Obesity Surgery Services</i>	90% per service after Calendar Year deductible	80% per service after Calendar Year deductible

Transplant Services Facility and Non-Facility Expenses

Your coverage will be considered network if provided at a participating Institutes of Excellence facility only. Your coverage will be considered out-of-network if it is not provided at an Institutes of Excellence facility.

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<i>Facility Expenses</i>	90% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
<i>Physician</i> (including office visits)	90% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>		
<i>Acupuncture in-lieu of anesthesia</i>	90% after Calendar Year deductible	80% per item after the Calendar Year deductible
<i>Ground, Air or Water Ambulance</i>	90% after Calendar Year deductible	90% after Calendar Year deductible
Non Emergency Ambulance		50% after Calendar Year deductible
<i>Durable Medical and Surgical Equipment</i>	90% per item after the Calendar Year deductible	80% per item after the Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	90% per item after the Calendar Year deductible	80% per item after the Calendar Year deductible
<i>Prosthetic Devices</i>	90% per item after the Calendar Year deductible	80% per item after the Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Therapies</i>		
<i>Chemotherapy</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Infusion Therapy</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Radiation Therapy</i>	90% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Outpatient Physical, Occupational and Speech Therapy combined</i>	90% per visit after the Calendar Year deductible	80% per visit after the Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Spinal Manipulation</i>		
	90% per visit after the Calendar Year deductible	80% per visit after the Calendar Year deductible

Expense Provisions

The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

The **deductible** is the portion of covered expenses you pay each year before the plan starts to pay benefits.

Individual Deductible

The individual **deductible** applies separately to you. Once your covered expenses reach the individual **deductible** amount in a calendar year, the plan will begin to pay benefits.

Family Deductible

The family **deductible** applies to you and your covered family members as a group. When the combined **covered expenses** of you and your family reach the family **deductible**, you and your family will be considered to have met all of your individual deductibles for that calendar year.

Network Deductible

This is an amount of **network covered expenses** incurred each Calendar Year for which no benefits will be paid. After **covered expenses** reach the **network Calendar Year deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Out-of-Network Deductible

This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. After **covered expenses** reach the **out-of-network Calendar Year deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Out-of-Pocket Maximum

The **Out-of-Pocket Maximum** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you meet the **Out-of-Pocket Maximum**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits.

This plan has an Individual and Family **Maximum Out-of-Pocket Maximum**.

For purposes of the provision, the **Individual Out-of-Pocket Maximum** applies to a person enrolled for employee only coverage (with no dependent coverage). Once the amount of eligible expenses you have paid during the Calendar Year meets the individual **Out-of-Pocket Maximum**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year.

The **Family Out-of-Pocket Maximum** applies to a person enrolled with one or more dependents. Once the amount of eligible expenses you or your covered dependents have paid during the Calendar Year meets the Family **Out-of-Pocket Maximum**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Maximum Out-of-Pocket limit** will be applied to satisfy the in-network **Maximum Out-of-Pocket limit** and **covered expenses** applied to the in-network **Maximum Out-of-Pocket limit** will be applied to satisfy the out-of-network **Maximum Out-of-Pocket limit**.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*), and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction

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

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

- A \$400 benefit reduction will be applied separately to each type of expense.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.

Plan Features for Prescription Drug

Prescription Drug Services

Plan Features	In-Network Coverage	Out-of-Network Coverage
	Managed by Medco	Managed by Medco
Local Participating Pharmacies (including insulin; generics required when available)	Tier 1: \$5 Tier 2: \$20 Tier 3: \$40 Up to a 30 day supply Deductible waived for preventative medications.	Deductible then reimbursed 100% of the Medco Health negotiated rate, less the applicable copay. Deductible waived for preventative medications.
Home Delivery	Tier 1: \$10 Tier 2: \$40 Tier 3: \$60 Up to a 90 day supply Deductible waived for preventative medications	Not covered

Preventative medications are not subject to the deductible. Please refer to Medco’s Preventative Medication List for examples of your plan’s preventative medications by drug category. This list includes both medications that are always prescribed for prevention and medications that are sometimes prescribed for prevention but may also be prescribed for treatment of an existing condition.

Medco has a broad network that includes more than 58,000 pharmacies nationwide, a convenient home-delivery service for easy ordering of refills, a full complement of Internet services at www.medcohealth.com, sophisticated drug use checks and balances, a round-the-clock clinical hotline for patients, and well-trained member service representatives.

You can call Medco Member Services at 800-230-0508 or log on to www.medco.com to find out whether a particular pharmacy is participating, order identification cards, or confirm if your medication has a generic version.

You will receive a Medco Identification Card once your enrollment materials have been completed and submitted to Cornell University’s Benefits Services. Note: The I.D. number is your Employee I.D. number not your Social Security Number. If you have questions about your employee I.D. number, call Benefits Services at 607-255-3936.

BENEFIT PLAN

**Prepared Exclusively for
Cornell University**

**HDHP/HSA Eligible Plan for Active
Employees, Under 65 Retirees and
Dependents**

**What Your Plan
Covers and How
Benefits are Paid**



Table of Contents

Preface	1	Anesthetics	
Important Information Regarding Availability of Coverage		Alternatives to Physician Office Visits	
Coverage for You and Your Dependents.....	2	Hospital Expenses.....	21
Health Expense Coverage	2	Room and Board	
Treatment Outcomes of Covered Services		Other Hospital Services and Supplies	
When Your Coverage Begins	3	Outpatient Hospital Expenses	
Who Can Be Covered	3	Coverage for Emergency Medical Conditions	
Employees		Coverage for Urgent Conditions	
Eligible Classes		Alternatives to Hospital Stays	23
Determining if You Are in an Eligible Class		Outpatient Surgery and Physician Surgical Services	
Obtaining Coverage for Dependents		Birthing Center	
How and When to Enroll.....	5	Home Health Care	
Initial Enrollment in the Plan		Private Duty Nursing	
Late Enrollment		Skilled Nursing Facility	
Annual Enrollment		Hospice Care	
Special Enrollment Periods		Other Covered Health Care Expenses	27
When Your Coverage Begins.....	7	Acupuncture	
Your Effective Date of Coverage		Ambulance Service	
Your Dependent's Effective Date of Coverage		Ground Ambulance	
Retired Employees		Air or Water Ambulance	
How Your Medical Plan Works	9	Diagnostic and Preoperative Testing	28
Common Terms.....	9	Diagnostic Complex Imaging Expenses	
Your HDHP/HSA Aetna Choice POS II Medical Plan	9	Outpatient Diagnostic Lab Work and Radiological Services	
About Your HDHP/HSA Aetna Choice POS II Medical Plan	10	Outpatient Preoperative Testing	
Availability of Providers		Durable Medical and Surgical Equipment (DME)	29
How Your Aetna Choice POS II Medical Plan Works.....	11	Experimental or Investigational Treatment.....	30
Understanding Precertification		Pregnancy Related Expenses	30
Services and Supplies Which Require Precertification:		Prosthetic Devices.....	31
Emergency and Urgent Care.....	14	Short-Term Rehabilitation Therapy Services.....	31
In Case of a Medical Emergency		Cardiac and Pulmonary Rehabilitation Benefits	
Coverage for Emergency Medical Conditions		Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits	
In Case of an Urgent Condition		Reconstructive or Cosmetic Surgery and Supplies	33
Coverage for an Urgent Condition		Reconstructive Breast Surgery	
Non-Urgent Care		Specialized Care.....	34
Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition		Chemotherapy	
Requirements For Coverage	17	Radiation Therapy Benefits	
What The Plan Covers	18	Outpatient Infusion Therapy Benefits	
Aetna Choice POS II Medical Plan	18	Enteral Formulas.....	35
Wellness.....	18	Treatment of Infertility.....	35
Routine Physical Exams		Basic Infertility Expenses	
Routine Cancer Screenings		Advanced Reproductive Technology (ART) Benefits	
Family Planning Services		Exclusions and Limitations	
Vision Care Services		Spinal Manipulation Treatment	36
Limitations		Transplant Services	36
Hearing Exam		Network of Transplant Specialist Facilities	
Physician Services	20	Obesity Treatment	38
Physician Visits			
Surgery			

Alcoholism, Substance Abuse and Mental Disorders Treatment.....	39	General Provisions	61
Treatment of Mental Disorders		Type of Coverage	61
Alcoholism and Substance Abuse		Physical Examinations.....	61
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth).....	41	Legal Action	61
Medical Plan Exclusions	43	Confidentiality.....	61
When Coverage Ends	51	Additional Provisions	61
When Coverage Ends For Employees		Assignments	62
Continuation of Coverage	53	Misstatements	62
Continuing Health Care Benefits		Incontestability	62
Handicapped Dependent Children		Subrogation and Right of Reimbursement	63
COBRA Continuation of Coverage.....	54	Worker's Compensation.....	64
Continuing Coverage through COBRA		Recovery of Overpayments	64
Who Qualifies for COBRA		Health Coverage	
Disability May Increase Maximum Continuation to 29 Months		Reporting of Claims.....	64
Determining Your Contributions For Continuation Coverage		Payment of Benefits.....	65
When You Acquire a Dependent During a Continuation Period		Records of Expenses	65
When Your COBRA Continuation Coverage Ends		Contacting Aetna.....	65
Coordination of Benefits - What Happens When There is More Than One Health Plan.....	57	Effect of Benefits Under Other Plans	66
Other Plans Not Including Medicare	57	Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage	
When You Have Medicare Coverage.....	60	Effect of Prior Coverage - Transferred Business	66
Effect of Medicare.....	60	Discount Programs	67
		Discount Arrangements	
		Incentives.....	67
		Glossary	68
		Appeal Procedure	

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

Preface

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

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

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

If you become covered, this *Booklet* replaces and supersedes all *Booklets* describing similar coverage that **Aetna** previously issued to you.

Customer:	Cornell University
Contract Number:	397366
Contract Effective Date:	January 1, 2009
Issue Date:	May 3, 2010
Booklet Number:	9



Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage

No services are covered under this *Booklet* in the absence of payment of current fees.

Coverage for You and Your Dependents

Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is “incurred” on the day you receive a health care service or supply. This plan provides coverage for the following:

- Medical Plan

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered. Conditions that are related to pregnancy may be covered under this plan.

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

Treatment Outcomes of Covered Services

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

When Your Coverage Begins

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

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

Who Can Be Covered

Employees

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

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

Eligible Classes

You are in an eligible class if:

- You are a retired employee of an employer participating in this plan, and you:
 - Retired before the effective date of this plan and were covered under the prior plan for health care coverage on the day before you retired; or
 - Were covered under this plan or another plan sponsored by your employer on the day before you retired; and
 - Have completed 10 years of benefit eligible service and are age 55 or older.

Determining if You Are in an Eligible Class

You are in an eligible class if:

1. A Regular Employees who works at least 20 hours per week for at least 6 months.
2. A Member of the Faculty or Academic Staff of the Endowed Colleges who is employed at least one full semester at a time; or
3. A Postdoctoral Fellow or visiting fellow without salary in a Statutory Division of Cornell

Determining When You Become Eligible

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

On the Effective Date of the Plan

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

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

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

Obtaining Coverage for Dependents

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

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

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

Coverage for Same Sex Partner

To be eligible for coverage, you and your same sex partner will need to complete and sign a Declaration of Same Sex Partnership. If you have completed and signed a statement of Same Sex Partnership and the statement is acceptable to your employer, you may cover as your dependent the person who is the same sex partner named in your statement.

Imputed Income Assessed on Same Sex Partners

The value of the health benefits your partner receives is viewed as taxable income based on the Internal Revenue Code. Same-sex partners do not meet the IRS's definition of a dependent. When an employer provides a benefit to someone other than a dependent (as defined by the Internal Revenue Code), the value of the benefit provided must be calculated into the gross income of the employee for tax purposes. Faculty and staff who cover a partner should be aware that this may increase their federal and state taxes.

The imputed income is the total amount Cornell University contributes toward coverage less the amount Cornell contributes for employee-only coverage. The value is added into your gross income per pay period. The tax implications vary by individual and you may need to seek the advice of your tax advisor.

If you are enrolled in a coverage level other than employee-only, and are adding your partner to your coverage, your imputed income is calculated on the value of Cornell University's contribution for employee-only coverage.

The cost of coverage for your same-sex partner must be paid on an after-tax basis and will be deducted from your paycheck. The cost of coverage is the amount you pay versus the amount the University contributes towards the cost of the level of coverage you have (Imputed Income is calculated on the University portion).

Coverage for Dependent Children

To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
- Under age 25, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*.

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

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;

- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

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

Important Reminder

Keep in mind that you cannot receive coverage under the plan as:

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

How and When to Enroll

Initial Enrollment in the Plan

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

You will need to enroll within 60 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Section 125, the Internal Revenue Code and related regulations which govern certain aspects of the plan's operation prohibit employees from making a change in coverage during the year unless they experience a Qualified Change in Family Status or a Special Termination Event. Those circumstances are described in the Special Enrollment Periods section of this Summary of Coverage. Of course, you can always change your coverage election during the annual enrollment period each November. Changes made during the annual enrollment period are effective January 1 of the following year. Our plan is administered in this manner to comply with IRS regulations.

Late Enrollment

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

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

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

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective January 1.

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

Special Enrollment Periods

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

Loss of Other Health Care Coverage

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

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

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

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

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

New Dependents

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

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 60 days of acquiring the dependent.

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

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 60 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to **Cornell Benefit Services** within 60 days of the change. If you do not return the form within 60 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child

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

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

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 60 days of the placement.
- Proof of placement will need to be presented to **Cornell Benefit Services** prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

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

- The child meets the plan's definition of an eligible dependent; and
- You complete an enrollment form. Child will automatically be enrolled in the event a form is not completed.

Coverage for the dependent will become effective on the date of the court order.

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

When Your Coverage Begins

Your Effective Date of Coverage

If you have met all the eligibility requirements, your coverage takes effect on your eligibility date.

If you do not return your completed enrollment information within 60 days of your eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Important Notice:

You must pay the required contribution in full retroactive to your eligibility date.

Your Dependent's Effective Date of Coverage

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

Note: New dependents need to be reported to **Cornell Benefit Services** within 60 days because they may affect your contributions. If you do not report a new dependent within 60 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Retired Employees

Retirees who do not continue coverage for any reason will not be allowed to re-enroll at a later date.

How Your Medical Plan Works

Common Terms

Accessing Providers

Precertification

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

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

Important Notes

- Unless otherwise indicated, “you” refers to you and your covered dependents. You can refer to the *Eligibility* section for a complete definition of ‘you’.
- Your health plan pays benefits only for services and supplies described in this Booklet as **covered expenses** that are **medically necessary**.
- This Booklet applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this Booklet in a safe place for future reference.

Common Terms

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

Your HDHP/HSA Aetna Choice POS II Medical Plan

Your HDHP/HSA Plan is health coverage plus a health savings account (HSA) rolled into one. It includes:

- A high-deductible health plan that provides health care coverage (the Aetna Choice POS II Medical Plan); and
- A health savings account to spend or save.

You visit your doctor for health care and the Plan will pay for covered services. You may be asked by your doctor to pay your share of the cost at the time of your visit or your doctor may bill you afterward. You can use the money in your HSA to pay for qualified medical expenses or you can pay the expenses out of your pocket and save the money in your HSA.

Important Note

For additional information regarding health savings accounts, please access the Cornell University Division of Human Resources website or contact Member Services at 1-877-371-2007.

About Your Aetna HDHP/HSA Aetna Choice POS II Medical Plan

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

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

This HDHP/HSA Aetna Choice POS II plan provides access to covered benefits through a network of health care providers and facilities. These **network providers** have contracted with **Aetna**, an affiliate or third party vendor to provide health care services and supplies to **Aetna** plan members at a reduced fee called the **negotiated charge**. This HDHP/HSA Aetna Choice POS II plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your **deductibles, copayments, and coinsurance** will generally be lower when you use participating **network providers** and facilities.

You also have the choice to access licensed **providers, hospitals** and facilities outside the network for covered benefits. Your out-of-pocket costs will generally be higher. **Deductibles, copayments, and coinsurance** are usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan.

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

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

Availability of Providers

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

Ongoing Reviews

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

To better understand the choices that you have with your HDHP/HSA Aetna Choice POS II plan, please carefully review the following information.

How Your Aetna Choice POS II Medical Plan Works

Important Note

ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care providers. If you have not received your ID card or if your card is lost or stolen, notify us immediately by calling 1-877-371-2007 and a new card will be issued.

Accessing Network Providers and Benefits

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

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

Cost Sharing For Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*. (If your coverage is Employee and Family, your individual deductible amount is the same as the family deductible amount.)

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

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

Cost Sharing for Out-of-Network Benefits

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

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

Understanding Precertification

Precertification

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

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

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

Important Note

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

The Precertification Process

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

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

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

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

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

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

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna's** decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the *Claim Procedures/Complaints and Appeals /Dispute Resolution* section of this Booklet.

Services and Supplies Which Require Precertification

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital**
- **Stays** in a **skilled nursing facility**
- **Stays** in a **rehabilitation facility**
- **Stays** in a **hospice** facility
- Outpatient **hospice care**
- **Stays** in a **treatment facility** for treatment of mental disorders, alcoholism or drug abuse treatment
- **Home health care**
- Private duty nursing care

How Failure to Precertify Affects Your Benefits

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

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

How Your Benefits for Inpatient and Outpatient Care, Procedures and Treatment are Affected

The chart below illustrates the effect on your benefits if necessary **precertification** for outpatient or inpatient services, procedures and treatments is not obtained.

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

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

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

Emergency and Urgent Care

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

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

In Case of a Medical Emergency

An **emergency medical condition** is a recent and severe condition, sickness, or **injury**, including (but not limited to) severe pain, which would lead a prudent layperson (including the parent or guardian of a minor child or the guardian of a disabled individual) possessing an average knowledge of medicine and health, to believe that failure to get immediate medical care could result in:

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

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

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **physician** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **physician** as soon as reasonably possible.
- If you seek care in an emergency rooms for a non-emergency condition (one that does not meet the criteria above), your benefits will be reduced. Please refer to the *Schedule of Benefits* for specific details about the plan.

Coverage for Emergency Medical Conditions

The plan will pay for **hospital** services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

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

Please contact a **physician** after receiving treatment of an **emergency medical condition**.

Important Reminder

If you visit a **hospital** emergency room for a non-emergency condition, the plan will pay a reduced benefit, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

In Case of an Urgent Condition

An **urgent condition** is a sudden **illness, injury** or condition that:

- Requires prompt medical attention to avoid serious deterioration of your health;
- Cannot be adequately managed without urgent care or treatment;
- Does not require the level of care provided in a **hospital** emergency room; and
- Requires immediate outpatient medical care that cannot wait for your **physician** to become available.

Call your **physician** if you think you need urgent care. **Physicians** usually provide coverage 24 hours a day, including weekends and holidays for urgent care. You may contact any **physician** or **urgent care provider**, for an **urgent care condition** if you cannot reach your **physician**.

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

Coverage for an Urgent Condition

The plan will pay for the services of an **urgent care provider** to evaluate and treat an **urgent condition**.

Your coverage includes:

- Use of urgent care facilities;
- **Physician** services;
- Nursing services; and
- Staff radiologists and pathologists services.

Non-Urgent Care

If you seek care from an **urgent care provider** for a non-urgent condition (one that does not meet the criteria above), the plan will not cover the expenses you incur. Please refer to the *Schedule of Benefits* for specific plan details.

Important Reminder

If you visit an **urgent care provider** for a non-urgent condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*.

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

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

For coverage purposes, follow-up care is treated as an expense for routine **illness** or **injury**. If you access a **hospital** emergency room for follow-up care, your coverage will be reduced and you will be responsible for more of the cost of your treatment. Refer to your *Schedule of Benefits* for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be provided by a **physician**.

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

Important Notice

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

Requirements For Coverage

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

1. The service or supply or **prescription drug** must be covered by the plan. For a service or supply to be covered, it must:
 - Be included as a covered expense in this Booklet;
 - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
 - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
 - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.
2. The service or supply must be provided while coverage is in effect. See the *Eligibility, Enrollment and Effective Date of Coverage, When Coverage Ends and Continuation of Coverage* sections for details on when coverage begins and ends.
3. The service or supply must be **medically necessary**. To meet this requirement, the medical services, supply must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms. The provision of the service or supply must be:
 - (a) In accordance with generally accepted standards of medical practice;
 - (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
 - (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
 - (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

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

Important Note

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

What The Plan Covers

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

Aetna Choice POS II Medical Plan

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

Wellness

This section on Wellness describes the **covered expenses** for services and supplies provided when you are well. Refer to the *Schedule of Benefits* for the frequency limits that apply to these services, if not shown below.

Routine Physical Exams

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

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

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

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

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

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

Important Reminder

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

Routine Cancer Screenings

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

- 1 mammogram every calendar year for covered females;
- 1 Pap smear every calendar year;
- 1 gynecological exam every calendar year;
- 1 fecal occult blood test every calendar year; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every calendar year for covered males age 40 and older.

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

- 1 Sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk); *or*
- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer.

Family Planning Services

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

Contraception Services

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

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

*Not covered are:

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

*These services may be covered under your Pharmacy Benefit Plan.

Other Family Planning

Covered expenses include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

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

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

Vision Care Services

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

- **Routine** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 2 calendar years.

Limitations

Unless specified above, the benefit plan does not cover charges for a service or supply furnished by other than a **network provider**.

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

Hearing Exam

Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist; or
- An audiologist who:
 - Is legally qualified in audiology; or
 - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
 - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for every two calendar years.

All **covered expenses** for the routine hearing exam are subject to any applicable **deductible, copay** and **payment percentage** shown in your *Schedule of Benefits*.

Physician Services

Physician Visits

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

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

Surgery

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

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

Anesthetics

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

Important Reminder

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

Alternatives to Physician Office Visits

Walk-In Clinic Visits

Covered expenses include charges made by network **walk-in clinics** for:

Unscheduled, non-emergency illnesses and injuries; and the administration of certain immunizations administered within the scope of the clinic's license.

Hospital Expenses

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

Room and Board

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

Room and board charges also include:

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

Other Hospital Services and Supplies

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

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

- **Ambulance** services.
- **Physicians** and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

Outpatient Hospital Expenses

Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

Important Reminders

The plan will only pay for nursing services provided by the **hospital** as part of its charge.

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

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

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

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

Coverage for Emergency Medical Conditions

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

The **emergency care** benefit covers:

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

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

Important Reminder

If you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

Coverage for Urgent Conditions

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

Your coverage includes:

- Use of urgent care facilities;
- **Physicians** services;
- Nursing staff services; and
- Radiologists and pathologists services.

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

If you visit an **urgent care provider** for a non-urgent condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services

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

- An office-based surgical facility of a **physician** or **dentist**;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

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

Important Note

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

The following outpatient surgery expenses are covered:

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

Limitations

Not covered under this plan are charges made for:

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

Birthing Center

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

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

Limitations

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

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

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

Home Health Care

Covered expenses include charges for home health care services when ordered by a **physician** as part of a home health plan and provided you are:

- Transitioning from a **hospital** or other inpatient facility, and the services are in lieu of a continued inpatient **stay**; or
- **Homebound**

Covered expenses include only the following:

- **Skilled nursing services** that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a **hospital** or **skilled nursing facility** after an inpatient **stay**, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous **skilled nursing services**. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.

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

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

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are not met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Note: Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed in the Therapy Services section.

Limitations

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

- Services or supplies that are not a part of the **Home Health Care Plan**.
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your same-sex partner's family.
- Services of a certified or licensed social worker.
- Services for physical, occupational and speech therapy.
- Services for Infusion Therapy.

- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are **custodial care**.

Important Reminders

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

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

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

Private Duty Nursing

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

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

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

Limitations

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

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

Skilled Nursing Facility

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

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

Important Reminders

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

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

Limitations

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

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

Hospice Care

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

Facility Expenses

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

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

Outpatient Hospice Expenses

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

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

- Medical supplies.
- *Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

*Prescription Drugs are covered under your Pharmacy Benefit Plan through Medco.

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

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

Limitations

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

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

Important Reminders

Refer to the *Schedule of Benefits* for details about **hospice care** maximums.

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

Other Covered Health Care Expenses

Acupuncture

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

- As a form of anesthesia in connection with a covered surgical procedure.

Ambulance Service

Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance

Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient **stay** at a **hospital, skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

Air or Water Ambulance

Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **hospital** to another **hospital**; when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**; **and** the two conditions above are met.

Limitations

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

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

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

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

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

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

Limitations

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

Outpatient Diagnostic Lab Work and Radiological Services

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

Important Reminder

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

Outpatient Preoperative Testing

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

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

Limitations

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

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

Important Reminder

Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply. Refer to your *Schedule of Benefits* for information on cost sharing amounts for complex imaging.

Durable Medical and Surgical Equipment (DME)

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

The initial purchase of **DME** if:

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

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

Replacement of purchased equipment if:

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

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

Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Important Reminder

Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible, payment percentage** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

Experimental or Investigational Treatment

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

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

Pregnancy Related Expenses

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

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

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

If the mother is discharged earlier, the plan will pay for one post-delivery home visits by a health care provider.

Covered expenses for a **birthing center** are described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision.

Prosthetic Devices

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

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

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

Covered expenses also include replacement of a prosthetic device if:

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

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

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

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

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

Short-Term Rehabilitation Therapy Services

Covered expenses included charges for short-term therapy services when prescribed by a **physician** as described below up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital, skilled nursing facility, or hospice facility**;
- A **home health care agency**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits.

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet**.

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Refer to the *Schedule of Benefits* for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in your home, if you are **homebound**.

Important Reminder

Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.

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

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down's Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services for the treatment of delays in speech development, unless resulting from: illness; **injury**; or congenital defect;
- Services provided during a **stay** in a **hospital, skilled nursing facility, or hospice facility except as stated above**;
- Services not performed by a **physician** or under the direct supervision of a **physician**;
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your same sex partner;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a **physician, hospital, or surgery center** for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Note: Injuries that occur as a result of a medical (*i.e.*, non surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
 - the defect results in severe facial disfigurement, or
 - the defect results in significant functional impairment and the surgery is needed to improve function

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Specialized Care

Chemotherapy

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

Radiation Therapy Benefits

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

Outpatient Infusion Therapy Benefits

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

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

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

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

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

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

* Enteral formulas are covered under your Pharmacy Benefit Plan through Medco

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

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

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

Important Reminder

Refer to the *Schedule of Benefits* for details on any applicable **deductible, payment percentage** and maximum benefit limits.

Modified Solid Food Products

Covered expenses include charges incurred for modified solid food products that are low in protein or which contain protein, which are prescribed by a **physician** for the treatment of certain diseases which include, but are not limited to:

- inherited diseases of amino acid or organic acid metabolism;
- Crohn's disease;
- gastroesophageal reflux with failure to thrive;
- disorders of gastrointestinal motility;
- multiple, severe food allergies.

Treatment of Infertility

Basic Infertility Expenses

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Artificially Assisted Fertilization or Advanced Reproductive Technology (ART) Benefits

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

Even though not incurred for treatment of an illness or injury, the following infertility services expenses are payable, subject to all the exclusions and limitations of this Booklet:

- Ovulation induction with menotropins is subject to the infertility lifetime maximum benefit shown in the Schedule of Benefits; and
- Intrauterine insemination is subject to the infertility lifetime maximum benefit shown in the Schedule of Benefits;

ART is defined as:

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

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

Exclusions and Limitations

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

- **ART** services for a female attempting to become pregnant who has *not* had at least 1 year or more of timed, unprotected coitus;
- **ART** services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of sterilization surgery;
- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or

surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits;
- Injectable **infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
- **Infertility** Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not **infertile**.

Important Note

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

Spinal Manipulation Treatment

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

Transplant Services

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

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant)
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant)
- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

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

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

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the **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 parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

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

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; **or** upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from an **IOE** facility will be considered network care expenses.

Important Reminders

To ensure coverage, all transplant procedures need to be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for details about **precertification**.

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

Limitations

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

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- 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**.

Network of Transplant Specialist Facilities

Through the **IOE** network, you will have access to a provider network that specializes in transplants. Benefits may vary if an **IOE** facility or non-**IOE** or **out-of-network provider** is used. In addition, some expenses are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Obesity Treatment

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

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

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

But only when you have a:

- **Body mass index (BMI)** exceeding 40; or
- BMI greater than 35 in conjunction with any of the following co-morbidities any one of which is aggravated by the obesity:
 - Coronary heart disease;
 - Type 2 diabetes mellitus;
 - Clinically significant obstructive sleep apnea; or
 - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management).

Limitations

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

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

Important Reminder

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

Alcoholism, Substance Abuse and Mental Disorders Treatment

Covered expenses include charges made for the treatment of alcoholism, **substance abuse** and **mental disorders** by **behavioral health providers**.

Important Notice

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

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of other **mental disorders** by **behavioral health providers**. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **behavioral health provider**;
- The plan includes follow-up treatment; and
- The plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

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

Inpatient Treatment Benefit Exchanges for Treatment of Mental Disorders

When preauthorized by **Aetna**, one day of full-time confinement for treatment of a **mental disorder** may be exchanged for up to:

- 2 **partial confinement treatment** sessions; or
- 4 outpatient visits.

In any one Calendar Year, not more than 10 days of full-time confinement can be exchanged for treatment of **mental disorders**.

Partial Confinement Treatment

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

Outpatient Treatment

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

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

Inpatient Benefit Exchanges

When preauthorized by **Aetna**, 1 mental health inpatient day may be exchanged for up to 4 outpatient visits or 2 days of partial **hospitalization**. No more than 10 inpatient days can be exchanged in a Calendar Year.

Important Reminder:

Inpatient care must be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for more information about **precertification**.

Alcoholism and Substance Abuse

Covered expenses include charges made for the treatment of alcoholism and **substance abuse** by **behavioral health providers**. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

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

The *Schedule of Benefits* shows the benefits payable and applicable benefit maximums for the treatment of alcoholism and **substance abuse**.

Inpatient Treatment for Alcoholism and Substance Abuse

The plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital or residential treatment facility**, appropriately licensed by the State Department of Health or its equivalent.

Coverage includes:

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

Outpatient Treatment for Alcoholism and Substance Abuse

The plan covers outpatient treatment of alcoholism or **substance abuse**.

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

Partial Confinement Treatment for Alcoholism and Substance Abuse

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

The **partial confinement treatment** will only be covered if you would need a **hospital stay** if you were not admitted to this type of facility.

Important Reminder:

Inpatient care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when **not** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:

- (a) Natural teeth damaged, lost, or removed; or
- (b) Other body tissues of the mouth fractured or cut due to **injury**.

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

The treatment must be completed in the Calendar Year of the **accident** or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the **injury**.

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

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

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

If a child needs oral surgery as the result of accidental **injury** or trauma, surgery may be postponed until a certain level of growth has been achieved.

Note: Trauma which occurs as a result of biting or chewing is *not* considered accidental **injury**, even if it is unplanned or unexpected.

Pathology

- The plan covers removal of tumors and cysts requiring pathological examination.

Radiation Treatment

- The plan covers fluoride treatment, removal of teeth and hyperbaric oxygen therapy in connection with covered radiation therapy.

Anatomical Defects

- The plan covers oral surgery and related dental services to correct a gross anatomical defect present at birth that results in significant functional impairment of a body part, if the services or supplies will improve function.

Related Dental Services Are Limited To:

- The first placement of a permanent crown or cap to repair a broken tooth;
- The first placement of dentures or bridgework to replace lost teeth; and
- Orthodontic therapy to preposition teeth.

Dental implants are *not* covered.

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

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

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

Artificial organs: Any device intended to perform the function of a body organ.

Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Contraception, except as specifically described in the *What the Plan Covers* Section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**.
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;

- Breast augmentation;
- Otoplasty.

Costs for services resulting from the commission of, or attempt to commit a felony by the covered person.

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

Court ordered services, including those required as a condition of parole or release.

Custodial care.

Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of **dentists**, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States.
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of **non-covered expenses**;
- Performance enhancing steroids;
- Implantable drugs and associated devices;
- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drugs**;
- Self-injectable **prescription drugs** and medications;
- Any **prescription drugs**, injectables, or medications or supplies provided by the policyholder or through a third party vendor contract with the policyholder; and

- Any expenses for prescription drugs, and supplies covered under an Aetna Pharmacy plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs; except charges for education or special education or job training is covered provided it is part of an approved treatment plan given in the facility that is also providing medical or psychiatric treatment;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations:

- Any health examinations:
 - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
 - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
 - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
 - any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individuals primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as provided in the *What the Plan Covers* section.

Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:

- treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

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

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility; and
- Any tests, appliances, and devices for the improvement of hearing, including aids hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

Home and mobility: Any addition or alternation to a home, workplace or other environment, or vehicle and any related equipment or device, including:

- Bathroom equipment such as bathtub seats, benches, rails, and lifts;
- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, massage devices or over-bed tables;
- Equipment or supplies to aid sleeping or sitting, including electric beds, water beds, air beds, pillows, sheets, blankets, warming or cooling devices, elevating chairs, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alternations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alternations to any vehicle or transportation device.

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Home uterine activity monitoring.

Infertility: except as specifically described in the *What the Plan Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;

- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- ovulation induction and intrauterine insemination services if you are not fertile.

Maintenance Care

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

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

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

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

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services, except as specifically described in the *Private Duty Nursing* provision in the *What the Plan Covers* Section.

Repatriation of remains.

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

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

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

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

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

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

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

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

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

Services that are not covered under this Booklet.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Speech therapy for treatment of delays in speech development, except as specifically provided in the *What the Medical Plan Covers Section*. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What the Plan Covers* section.

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

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

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

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;

- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Transplant-The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise **precertified by Aetna**;
- services and supplies not obtained from an **IOE** including the harvesting of organs, bone marrow, tissue or stem cells for storage purposes.

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

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

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

- Anti-reflective coatings;
- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Tinting of eyeglass lenses;
- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as provided by this Booklet, including but not limited to:

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

Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or **injury** under such law, that illness or **injury** will be considered "non-occupational" regardless of cause.

When Coverage Ends

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your medical plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, **Aetna** may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan. as described below:
 - If you are not **actively at work** due to **illness or injury**, your coverage may continue, until stopped by your employer.

It is your employer's responsibility to let **Aetna** know when your employment ends.

Unless you provide notification to Benefit Services that you would like to continue health coverage within 60 days of the event, your current coverage will end on the last day of the pay period in which you received your last paycheck.

Continuing Coverage. Faculty and staff and/or their eligible family members may continue medical coverage should one of the following situations occur (provided that coverage is in effect on the date that event occurs):

- Family or Medical Leave
- Death or total disability
- Divorce or legal separation
- Layoff of a covered employee
- Retirement prior to eligibility for Medicare
- Veteran called to active duty
- University leave

For information on continuing your Health Savings Account (HSA) through JPMC, including Cornell's contribution to your Health Savings Account, please contact Aetna Member Services at 1-877-371-2007.

Family Medical Leave. Family Medical Leave entitles eligible faculty and staff to unpaid time away from work up to a total of 12 weeks. This is in accordance with the Family and Medical Leave Act (FMLA) of 1993. Be sure to contact the Division of Human Resources at Cornell University or review the Human Resource Policy.

You may continue your existing health insurance coverage during FML, provided you continue to pay for the employee share of premiums. The University contribution, if any, to the Health Savings Account ends. If you are taking a FML without pay, (and not using accrued sick or vacation) you will be billed by Records Administration. If you decide to terminate your health insurance coverage either at the start or during your FML, when you return from the leave, you have the right to have your health insurance reinstated on the same terms as prior to the leave.

Spouse, Same Sex Partner and Dependent Coverage After Your Death. In the event that a covered active employee dies while covered under this plan or a retiree dies prior to reaching age 65, the surviving spouse, same sex partner, and any current or future eligible covered dependent children may continue the health plan until the surviving spouse remarries or the same sex partner enters a new same sex partnership, and/or the dependent children no longer qualify under the program's definitions. The University contribution will continue, and the surviving spouse or same sex partner will be billed for any required employee or retiree contribution. The University contribution, if any, to the Health Savings Account ends.

Total Disability. A covered faculty or staff member who qualifies for long-term disability benefits can continue the coverage in effect at the time the disability occurs until the period of the disability ends. The University contribution will continue during the period of the approved disability leave and the faculty or staff member will be billed for any required contribution. If you become eligible for coverage under Medicare, you are no longer eligible to remain in the High Deductible Health Plan with HSA Plan. You and your dependents will need to transfer coverage to the Retiree Endowed 80/20 Plan upon eligibility for Medicare. Effective July 1, 2010, the Retiree Endowed 80/20 Plan is replaced by the Aetna PPO Plan for individuals who become Medicare eligible. Call Benefit Services at 607-255-3936 for more information. It is also your responsibility to enroll in Medicare parts A & B to assure continued coverage under the Endowed Retiree 80/20 Plan. The Retiree 80/20 plan will take Medicare's benefit into consideration even if you fail to enroll. If you fail to enroll then the portion Medicare would have paid will be your responsibility.

Divorce or Legal Separation. If you and your spouse decide to divorce or legally separate, or you and your same sex partner decide to terminate the same sex partnership, you (and any eligible dependents) can continue coverage. However, your ex-spouse/same sex partner will no longer be eligible to continue coverage under your plan but may be eligible to enroll in COBRA continuation coverage administered by Aetna. You will need to call Cornell University's Benefit Services at 607-255-3936 within 60 days of the divorce or legal separation, or termination of the same sex partnership, to complete an enrollment form and remove the dependent from coverage. In addition, you will need to include a copy of the divorce decree (front and back page only) as proof. Same-Sex Partners are required to complete a Termination of Same-Sex Partnership form.

Coverage During Layoff. Faculty or staff members who are no longer working because of a layoff or reduction in work force will continue to receive the University contribution toward the cost of health coverage for up to 12 months provided they enroll in COBRA continuation coverage administered by Aetna. The University contribution, if any, to the Health Savings Account ends. If COBRA coverage is elected, you will be billed monthly by Aetna's COBRA Direct Billing Unit for the employee portion of the cost of your health plan. At the end of 12 months, you will be billed at the full COBRA rate remaining six months for a total of 18 months of continuation coverage.

Coverage Upon Retirement. Your coverage can be continued into retirement if you are at least age 55 when you retire, and have at least 10 years of benefit eligible service. If you cancel the Health Plan at any time, you will not be allowed to re-enroll at a later date. The University contribution, if any, to the Health Savings Account ends.

If you are not yet 65 when you retire and are, therefore, not eligible for Medicare, you have the opportunity to continue coverage under this Plan. Upon attainment of age 65, you and your dependents will automatically be transferred to Cornell's Retiree 80/20 Plan, and you must enroll in Medicare Parts A&B. If you or your enrolled dependents fail to enroll in Medicare, then the Plan will take Medicare's benefit into consideration, and the portion Medicare would have paid will be your responsibility. Medicare may impose a penalty if you fail to enroll when first eligible. Contact Aetna's member services at 1-877-371-2007 to obtain information on what happens to your Health Savings Account if you are age 65 and older.

If you are not yet 65 when you retire but your enrolled spouse is over 65 and is also retired or otherwise qualifies for Medicare primary coverage, he or she must enroll in Medicare Parts A&B. If you are not yet 65 when you retire but your same-sex partner is over 65 he or she must enroll in Medicare Parts A&B regardless of status. If your spouse or same-sex partner fail to enroll, then the Plan will take Medicare's benefit into consideration, and the portion Medicare would have paid will be your responsibility. Medicare may impose a penalty if you fail to enroll when first eligible.

If you are 65 or older when you retire and are eligible for Medicare, you and your dependents will receive coverage under the Retiree 80/20 Plan. This coverage is described in a separate plan summary booklet that is available upon request from Benefit Services at Cornell University, 130 Day Hall, Ithaca, NY 14853, or call (607) 255-3936.

A faculty or staff member who retires and has not met the eligibility requirements for retiree medical coverage may be eligible to continue coverage under COBRA. If you retire before you turn 65 and are not enrolled or eligible for Medicare, you can continue coverage for up to 18 months or until you are enrolled for Medicare (whichever occurs first). If you retire after you turn 65 and are already enrolled for Medicare, you can continue coverage for up to 18 months. Eligible dependents may also be eligible to continue coverage under COBRA for up to 36 months. Please refer to the COBRA Continuation of Coverage section for complete details regarding Who Qualifies for COBRA and When Your COBRA Continuation Coverage Ends.

Coverage During University Leave. Staff members who voluntarily resign their positions and are granted a University leave are eligible to continue this Plan under COBRA. The University contribution, if any, to the Health Savings Account ends.

When Coverage Ends for Dependents

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

- Termination of all dependents' coverage under this Plan.
- When a dependent becomes covered as an employee.
- At the end of the calendar month in which such person is no longer a defined dependent. In the case of a full time student, coverage ends three months after the date of graduation. However, a full time student on an approved medical leave will continue to have coverage for up to one year.
- When your coverage terminates.

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

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

Continuation of Coverage

Continuing Health Care Benefits

Handicapped Dependent Children

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child.

Your child is fully handicapped if:

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

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 60 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

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

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

COBRA Continuation of Coverage

If your employer has more than 20 employees, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of contributions. Continuation rights are available following a “qualifying event” that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA

When you or your covered dependents become eligible, Aetna Inc's Direct Billing Unit will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of Aetna Inc's Direct Billing Unit notice of this COBRA continuation right, if later.
- Agree to pay the required contributions.

For information regarding continuation of your Health Savings Account, please contact Member Services at 1-877-371-2007.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
Your marriage is annulled, you divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

Note: If your active employment ends for a reason other than gross misconduct and you are not entitled to benefits under Medicare, you can continue coverage for a maximum continuation period of 18 months or until you are entitled to Medicare, whichever occurs first.

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify Aetna Inc's Direct Billing Unit at (800-429-9514) within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify Aetna Inc's Direct Billing Unit at (800-429-9514) within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the contributions after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Contributions For Continuation Coverage

Your contributions are regulated by law, based on the following:

- For the 18 or 36 month periods, contributions may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, contributions for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage*, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Aetna Inc's Direct Billing Unit is notified about your dependent within 60 days of eligibility, and
- Additional contributions for continuation are paid on a timely basis.

*marriage is limited to former employees only

Important Note

For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required contributions.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

Important Note

A Conversion Policy is not offered.

Coordination of Benefits - What Happens When There is More Than One Health Plan

Other Plans Not Including Medicare

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
 - secondary to the plan covering the person as a dependent; and
 - primary to the plan covering the person as other than a dependent;

The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

- covers the person as other than a dependent; and
 - is secondary to Medicare.
3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:
 - a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
 - b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
 - c. If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:

- laid-off or retired employee; or
- the dependent of such person;

Shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a calendar year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other plan" both agree that this Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

When You Have Medicare Coverage

Effect of Medicare

Effect of Medicare

Important Note

The HDHP/HSA Eligible Plan is not available to employees who are Medicare eligible regardless of employment status (active or retired) or age. Please contact Benefit Services at Cornell University, 130 Day Hall, Ithaca, NY 14853 or call (607) 255-3936.

General Provisions

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Pregnancy related conditions may not be covered under the plan. See the *Schedule of Benefits* for more information.

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Legal Action

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

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

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of the plan and administration of this Booklet, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna's** Notice of Information Practices by calling **Aetna's** toll-free Member Service telephone.

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *group contract*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

Assignments

Coverage may be assigned only with the written consent of **Aetna**. To the extent allowed by law, **Aetna** will not accept an assignment to an out-of-network provider, provider or facility including but not limited to, an assignment of:

- The benefits due under this contract;
- The right to receive payments due under this contract; or
- Any claim you make for damages resulting from a breach or alleged breach, of the terms of this contract.

Misstatements

If any fact as to the Contractholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Contractholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of this contract at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

As to **Accident** and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Contractholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Contractholder shall be the basis for voiding this Contract after it has been in force for 2 years from its effective date.
- No statement made by you, an eligible employee or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Subrogation and Right of Reimbursement

As used herein, the term “**Third Party**”, means any party that is, or may be, or is claimed to be responsible for **illness** or **injuries** to you. Such **illness** or **injuries** are referred to as “**Third Party Injuries.**” “**Third Party**” includes any party responsible for payment of expenses associated with the care of treatment of **Third Party Injuries.**

If this plan pays benefits under this Booklet-Certificate to you for expenses incurred due to **Third Party Injuries**, then **Aetna** retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the **Third Party Injuries.** **Aetna’s** rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a **Third Party** or any insurance company on behalf of the **Third Party**;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers’ Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners’ medical payments coverage or premises or homeowners’ insurance coverage; and
- Any other payments from a source intended to compensate you for **injuries** resulting from an accident or alleged negligence.

By accepting benefits under this plan, you specifically acknowledge **Aetna’s** right of subrogation. When this plan pays health care benefits for expenses incurred due to **Third Party Injuries**, **Aetna** shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this plan. **Aetna** may proceed against any party with or without your consent.

By accepting benefits under this plan, you also specifically acknowledge **Aetna’s** right of reimbursement. This right of reimbursement attaches when this plan has paid benefits due to **Third Party Injuries** and you or your representative has recovered any amounts from a **Third Party.** By providing any benefit under this Booklet-Certificate, **Aetna** is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. **Aetna’s** right of reimbursement is cumulative with and not exclusive of **Aetna’s** subrogation right and **Aetna** may choose to exercise either or both rights of recovery.

By accepting benefits under this plan, you or your representatives further agree to:

- Notify **Aetna** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to **Third Party Injuries** sustained by you;
- Cooperate with **Aetna** and do whatever is necessary to secure **Aetna’s** rights of subrogation and reimbursement under this Booklet-Certificate;
- Give **Aetna** a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with **Third Party Injuries** provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due **Aetna** as reimbursement for the full cost of all benefits associated with **Third Party Injuries** paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **Aetna** in writing; and
- Do nothing to prejudice **Aetna’s** rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of **Third Party Injuries.**

Aetna may recover full cost of all benefits paid by this plan under this Booklet-Certificate without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **Aetna's** recovery, and **Aetna** is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any **Third Party** without the prior express written consent of **Aetna**. In the event you or you representative fail to cooperate with **Aetna**, you shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by **Aetna** in obtaining repayment.

Worker's Compensation (GR 9N S- 32- 01 002 NH)

If benefits are paid by **Aetna** and **Aetna** determines you received Worker's Compensation benefits for the same incident, **Aetna** has the right to recover as described under the *Subrogation and Right of Reimbursement* provision. **Aetna** will exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily **injury** or **illness** was sustained in the course of or resulted from your employment;
- The amount of Worker's Compensation due to medical or health care is not agreed upon or defined by you or the Worker's Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this policy, you will notify **Aetna** of any Worker's Compensation claim you make, and that you agree to reimburse **Aetna** as described above.

If benefits are paid under this policy and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna** has a right to recover from you or your covered dependent an amount equal to the amount **Aetna** paid.

Recovery of Overpayments

Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

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

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

Reporting of Claims

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

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

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

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

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

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

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

When a **PCP** provides care for you or a covered dependent, or care is provided by a **network provider (network services or supplies)**, the **network provider** will take care of filing claims. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

Records of Expenses

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

Very important are:

- Names of **physicians, dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna's** Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna's** toll free Member Services phone number on your ID card or visit **Aetna's** web site at www.aetna.com.

Effect of Benefits Under Other Plans

Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care), if any, on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 60 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 60 days, coverage will take effect only if and when **Aetna** gives its written consent.

Any extensions of benefits under this plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan providing medical coverage. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- The end of a 90 day period; and
- The date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Prior Coverage - Transferred Business

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

If part or all of your **deductible** under any section of a prior **Aetna** Major or Comprehensive Medical Expense plan has been applied against covered medical expenses incurred by you, your **deductible** under any Aetna Choice POS II Medical Plan section of this plan will, for the Calendar Year in which you become covered, be reduced by the amount so applied. This will be done only if such expenses are incurred by you during:

- The Calendar Year in which you become covered under any Medical Plan section of this plan; or
- The last 3 months of the Calendar Year right before the year you coverage takes effect.

If any benefits have been paid to or accrued by you under any such section of your prior coverage, your maximum benefit under the Aetna Choice POS II Medical Plan section of this plan will be reduced. It will be reduced by the total amount of benefits still charged against your maximum benefit under your prior coverage on the day before you become covered under the Aetna Choice POS II Medical Plan section of this plan.

Discount Programs

Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and health living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

Incentives

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

Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet.

A

Accident

This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Contract. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

Aetna

Aetna Life Insurance Company

Ambulance

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Average Wholesale Price (AWP)

The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

B

Behavioral Health Provider/Practitioner

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

Birthing Center

A freestanding facility that meets **all** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
 - Complications arise during labor; or
 - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.

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

Body Mass Index

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

Brand-Name Prescription Drug

A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

C

Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic

Services or supplies that alter, improve or enhance appearance.

Covered Expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

Creditable Coverage

A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-CHIP).

Custodial Care

Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);

- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

D

Day Care Treatment

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

Deductible

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

Deductible Carryover

This allows you to apply any **covered expense** incurred during the last 3 months of a calendar year that is applied toward this year's **deductible** to also apply toward the following year's **deductible**.

Dentist

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

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory

A listing of all **network providers** serving the class of employees to which you belong. The contractholder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna's** online provider **directory**, DocFind®.

Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a **illness or injury**;
- Suited for use in the home;
- Not normally of use to people who do not have a **illness or injury**;

- Not for use in altering air quality or temperature; and
- Not for exercise or training.

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

E

E-visit

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

Effective Treatment of a Mental Disorder

This is a program that:

- Is prescribed; and supervised; by a **physician**; and
- Is for a **mental disorder** that can be favorably changed.

Emergency Care

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

Emergency Medical Condition

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

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

Experimental or Investigational

A drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is **experimental or investigational**, or for research purposes.

G

Generic Prescription Drug

A **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by **Aetna** or an affiliate.

H

Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of febleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
 - **Skilled nursing services**;
 - Medical social services; and
 - Psychological and dietary counseling.

- Provides, or arranges for, other services which include:
 - **Physician** services;
 - Physical and occupational therapy;
 - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
 - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
 - One **physician**;
 - One **R.N.**; and
 - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility

A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**
- Has a full-time administrator.

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and

- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

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

Hospitalization

Is necessary and continuous confinement as an inpatient in a **hospital** is required and a charge for **room and board** is made.

I

Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility

The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- *For a woman who is under 35 years of age:* 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- *For a woman who is 35 years of age or older:* 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury

An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

Institute of Excellence (IOE)

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

J

Jaw Joint Disorder

This is:

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

L

Late Enrollee

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

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

Lifetime Maximum

This is the most the plan will pay for **covered expenses** incurred by any one covered person during their lifetime.

L.P.N.

A licensed practical or vocational nurse.

M

Mail Order Pharmacy

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

Maintenance Care

Care made up of services and supplies that:

- Are furnished mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Out-of-Pocket Limit

Your plan has a **maximum out-of-pocket limit**. Your **deductibles**, **payment percentage copays** and other eligible out-of-pocket expense apply to the **maximum out-of-pocket limit**. Once you satisfy the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the calendar year. **The maximum out-of-pocket limit** applies to both network and out-of-network out-of-pocket expenses.

The following expenses do not apply toward your **maximum out-of-pocket limit(s)**:

- Charges over the **recognized charge**,
- **Non-covered expenses**, and
- Expenses that are not paid or precert benefit reductions made because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Medically Necessary or Medical Necessity

Health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms, and that provision of the service, supply or **prescription drug** is:

- a) In accordance with generally accepted standards of medical or dental practice;
- b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and

- c) Not primarily for the convenience of the patient, **physician**, other health care or **dental provider**; and
- d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

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

Mental Disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker. A **mental disorder** includes; but is not limited to:

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

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

Morbid Obesity

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

N

Negotiated Charge

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

Network Advanced Reproductive Technology (ART) Specialist

A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology (ART)** services.

Network Provider

A health care provider who 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 **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **PCP**.

Night Care Treatment

A **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital, psychiatric hospital or residential treatment facility**. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury

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

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

Non-Specialist

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

Non-Urgent Admission

An inpatient admission that is not an **emergency admission** or an **urgent admission**.

O

Occupational Injury or Occupational Illness

An **injury** or **illness** that:

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

Occurrence

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

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

Orthodontic Treatment

This is any:

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

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

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

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

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

Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is:

- Furnished by an **out-of network provider**; or
- Not furnished or arranged by your **PCP**.

Out-of-Network Provider

A health care provider who has not contracted with **Aetna** to furnish services or supplies at a **negotiated charge**.

P

Partial Confinement Treatment

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

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

Payment Percentage

Payment percentage is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “**plan payment percentage**,” and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **payment percentage** amounts.

Pharmacy

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician

A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

Precertification or Precertify

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Prescriber

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

Prescription

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

Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Physician (PCP)

This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician;
- Initiates **referrals** for **specialist** care and maintains continuity of patient care; and
- Is shown on **Aetna's** records as the person's **PCP**.

Psychiatric Hospital

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

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or **mental disorders**.

R

Recognized Charge

Only that part of a charge which is less than or equal to the **recognized charge** is a **covered benefit**. The **recognized charge** for a service or supply is the lowest of

- The provider's usual charge for furnishing it; and
- The charge **Aetna** determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or
 - a) For non-facility charges: **Aetna** uses the provider charge data from the Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months.
 - b) For facility charges: **Aetna** uses the charge **Aetna** determines to be the usual charge level made for it in the geographic area where it is furnished

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

- Unusual; or
- Not often provided in the geographic area; or
- Provided by only a small number of **providers** in the geographic area;

Aetna may take into account factors, such as:

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

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

As used above, the term “geographic area” means a Prevailing HealthCare Charges System (PHCS) expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are utilized.

Rehabilitation Facility

A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services

The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

Residential Treatment Facility (Alcoholism and Substance Abuse)

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

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

- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.
- On-site, licensed **Behavioral Health Provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

Residential Treatment Facility (Mental Disorders)

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

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

R.N.

A registered nurse.

Room and Board

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

S

Semi-Private Room Rate

The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.

Skilled Nursing Facility

An institution that meets all of the following requirements:

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

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include:

- Institutions which provide only:
 - Minimal care;
 - Custodial care services;
 - Ambulatory; or
 - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.

Skilled Nursing Services

Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care

Health care services or supplies that require the services of a **specialist**.

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Substance Abuse

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

Surgery Center

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

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
 - **Physicians** who practice surgery in an area **hospital**; and
 - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- **Physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

T

Terminally Ill (Hospice Care)

Terminally ill means a medical prognosis of 6 months or less to live.

U

Urgent Admission

A **hospital** admission by a **physician** due to:

- The onset of or change in a **illness**; or
- The diagnosis of a **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
 - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
 - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
 - Makes charges.
 - Is licensed and certified as required by any state or federal law or regulation.
 - Keeps a medical record on each patient.
 - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
 - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
 - Has a full-time administrator who is a licensed **physician**.
- A **physician's** office, but only one that:
 - Has contracted with **Aetna** to provide urgent care; and
 - Is, with **Aetna's** consent, included in the **directory** as a network **urgent care provider**.
- It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

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

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

W

Walk-in Clinic

Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a **physician's** office visit for treatment of unscheduled, non-emergency **illnesses** and **injuries** and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a **physician**. Neither an emergency room, nor the outpatient department of a **hospital**, shall be considered a **Walk-in Clinic**.

Additional Information Provided by

Cornell University

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

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

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

Employer Identification Number:

15-0532082

Plan Number:

502

Type of Plan:

Choice POS II High Deductible Health Plan with Health Savings Account

Type of Administration:

Administrative Services Contract with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

Vice President, Human Resources
Cornell University
130 Day Hall
Ithaca, NY 14853

Agent For Service of Legal Process:

Vice President, Human Resources
Cornell University
130 Day Hall
Ithaca, NY 14853

End of Plan Year:

December 31

Source of Contributions:

Paid by Employer and Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

ERISA Rights

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

Receive Information about Your Plan and Benefits

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

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

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

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

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 60 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 60 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your 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: A written request to Aetna to reconsider an **adverse benefit determination**.

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

Concurrent Care Claim Extension: A request to extend a 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 your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Claim Determinations

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 days claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15 calendar days 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. You 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 you 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 Termination

Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must 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 will also provide an option to request an external review of the **adverse benefit determination**.

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

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

The notice of an **adverse benefit determination** will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna's Customer Service Unit at the toll-free phone number on your ID card.

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

Level One Appeal - Group 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.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Level Two Appeal

If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, 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, a Pre-Service Claim, or a Post-Service Claim** shall be provided by Aetna personnel not involved in making an **adverse benefit determination**.

Urgent Care Claims (May Include **concurrent care claim reduction or termination**)

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

Pre-Service Claims (May Include **concurrent care claim reduction or termination**)

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

Post-Service Claims

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

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

Exhaustion of Process

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

- 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.

CORNELL UNIVERSITY – SELF-FUNDED HEALTH PLANS
NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL AND DENTAL INFORMATION
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS
INFORMATION.**

Please review it carefully.

Contact Information for Privacy Concerns or further information about this notice:

**PRIVACY OFFICER: Director of Benefits, 130 Day Hall, Cornell University, Ithaca, NY 14853
(phone (607) 255-3936; fax (607) 255-6873)**

ABOUT THIS NOTICE

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires Cornell University, which operates self-funded health plans and a fully insured dental plan (collectively “the Health Plans”) for its employees, to maintain the privacy of protected health information and to provide individuals with notice of its privacy practices with respect to such Health Plans. This notice outlines your rights with respect to the use of your information.

How the Benefit Services May Use or Disclose Your Health Information

The following categories describe the ways that the Health Plans and its contracted Health Plan vendors Aetna, Inc.; HealthNow New York, Inc; Medco Health Solutions; Triple S and Aon Consulting (collectively referred to as the “Health Plan Vendors” in this notice) may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

Payment Functions. The Health Plan Vendors may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. For example, payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a treatment is covered under your plan.

Business Associates. There are some services provided in our organization through contracts with business associates. The primary example of this is Cornell’s relationship with Aetna, HealthNow, Medco Health Solutions, Triple S and Aon Consulting, which are currently under contract with Cornell to administer different parts of the Health Plans. The Health Plan Vendors, therefore, will have access to your health information to conduct those activities. We require these business associates to safeguard your information appropriately.

Health Plan Operations. The Health Plan Vendors may use and disclose health information about you to carry out necessary Health Plan-related activities. For example, such activities may include underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration.

Treatment. The Health Plan Vendors may use or disclose information to doctors, dentists, pharmacies, hospitals or other health care providers who take care of you. For example, doctors may request medical information from the vendors to supplement their own records. The Health Plan Vendors may also send certain information to doctors for patient safety or other treatment-related reasons.

Worker’s Compensation. The Health Plan Vendors may also release information to comply with Worker’s Compensation or similar laws.

Public Health. As required by law, the Health Plan Vendors may be required to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health Oversight Activities. The Health Plan Vendors may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the operation of government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Health Plan Vendors may disclose medical information about you in response to a court or administrative order. The Health Plan Vendors may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made by the party requesting the information to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Health Plan Vendors may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; for military, national security and intelligence activities, or for protective services of the President and others.

Coroners, Medical Examiners and Funeral Directors. The Health Plan Vendors may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Health Plan Vendors may also release medical information to funeral directors as necessary to carry out their duties.

Marketing. The Health Plan Vendors may contact you to give you information about health-related benefits and services that may be of interest to you.

Disclosures to Us. The Health Plan Vendors may disclose information to Cornell, as the Plan sponsor, for purposes of administering benefits under the Health Plan.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. Such revocation shall be made in writing to the appropriate Health Plan Vendor: Aetna; HealthNow; Triple S; Aon Consulting, at the address given at the end of the Notice, which can provide you with the appropriate form. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, or that are necessary to obtain payment for your care.

Statement of Your Health Information Rights

Right to Inspect and Copy. You have the right to inspect and copy health information which any of the Health Plans has in a “designated record set”-- records used in making enrollment, payment, claims adjudication, medical management and other decisions. This right does not include: psychotherapy notes under certain circumstances; information compiled for use in a legal proceeding; or certain information maintained by laboratories.

In order to inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the appropriate Health Plan Vendor: Aetna; HealthNow; Medco Health Solutions; Triple S or Aon Consulting, at the address given at the end of the Notice. The Health Plan vendors can provide you with the appropriate form. If you request a copy of the information, they may charge a fee of \$0.75 per page for the costs of copying, mailing or other supplies associated with your request.

The Health Plan Vendors may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request in writing that the denial be reviewed, and details of the procedures for such review will be provided to you at that time.

Right to Amend. If you feel that medical information one of the Health Plans has about you in a “designated record set” is incorrect or incomplete, you may ask the Health Plan Vendor to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Health Plans.

To request an amendment, your request must be made in writing and submitted to the appropriate Health Plan Vendor: Aetna; HealthNow; Medco Health Solutions; Triple S; or Aon Consulting at the address given at the end of this Notice. In addition, you must provide a reason that supports your request.

The Health Plan Vendor may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, they may deny your request if you ask to amend information that:

- Was not created by the Health Plans, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Health Plans;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures.” This is a list of certain disclosures the Health Plan Vendors may have made of medical information about you. The list will not include disclosures that were made for treatment, payment or health care operations purposes, disclosures to our business associates, or disclosures made pursuant to an authorization that you signed. In addition, the Health Plans will not include on the list medical information about you that will compromise national security.

To request this list or accounting of disclosures, you must submit your request in writing to the appropriate Health Plan Vendor: Aetna, HealthNow, Triple S and Aon Consulting at the address given at the end of this Notice. Your request must state the time period with respect to which you are concerned about disclosures, may not be longer than six years, and may not include dates before April 14, 2003. The Health Plan Vendors will do their best to honor your request. If you make more than one request in a 12-month period, however, they may charge you for the costs of providing the list.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information the Health Plans use or disclose about you for treatment, claims payment or health care operations. You also have the right to request a limit on the medical information the Health Plans disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Your requests must be made in writing to the appropriate Health Plan Vendor: Aetna, HealthNow, Medco Health Solutions; Triple S and Aon Consulting at the address given at the end of this Notice.

The Health Plans are not required to agree to your request. If the Health Plan Vendor agrees to your request, they will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Confidential Communications. You have the right to request that the Health Plan Vendors communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Health Plan Vendors only contact you at work or by mail. To request confidential communications, you must make your request in writing to the appropriate Health Plan Vendor. They will accommodate all requests that they can reasonably accommodate without impeding efforts at treatment or payment. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to receive a paper copy of the Notice currently in effect at any time. Just contact the Privacy Officer at the address given at the beginning of this Notice. You may also obtain a copy of this notice at our website, www.ohr.cornell.edu

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at the address given at the beginning of the Notice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

Changes to this Notice of Privacy Practices

We may amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, the law requires the Health Plans to comply with the current version of this Notice.

Health Plan Vendor Addresses:

Aetna, Inc.	HealthNow	Triple S
P.O. Box 981109	P.O. Box 80	GPO Box 363628
El Paso, TX	Buffalo, NY 14240	San Juan, Puerto Rico 00936-3628
79998-1109		

Aon Consulting
Flex Administration #00559-80
P.O. Box 2845
Winston-Salem, NC 27102

Medco Health Solutions, Inc.
Privacy Services Unit
P.O. Box 800
Franklin Lakes, NJ 07417