Adobe

Aetna International Expat Plan

To go to a specific section, simply click on the title:

- PPO Medical & Pharmacy Booklet and Schedule of Benefits
- Comprehensive Dental Booklet, Schedule of Benefits and Orthodontia Rider
- Basic Vision Booklet and Schedule of Benefits
- Life Insurance Booklet and Schedule of Benefits
- Appeals Rider
- Aetna Domestic Partner Rider

- Effective January 1, 2016
BENEFIT PLAN

Prepared Exclusively For
Adobe Systems Incorporated

PPO Medical and Pharmacy

Aetna Life Insurance Company
Booklet-Certificate

What Your Plan Covers and How Benefits are Paid

This Booklet-Certificate is part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder.
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Preface (GR-9N-02-005-01 DE)

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

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

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

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

Group Policyholder: Adobe Systems Incorporated
Control Number: 447926
Effective Date: January 1, 2016
Issue Date: March 1, 2016
Booklet-Certificate Number: 1

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)
Important Information Regarding Availability of Coverage (GR-9N 02-005 02)

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

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

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

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

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

Benefits may be modified during the term of this plan as specifically provided under the terms of the Group Insurance Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the Group Insurance Policy or in this Booklet-Certificate beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.
Coverage for You and Your Dependents (GR-9N-02-005-01 DE)

Health Expense Coverage (GR-9N-02-020-01 DE)

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

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

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

Treatment Outcomes of Covered Services (GR-9N-02-020-01 DE)

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

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.

Determining if You Are in an Eligible Class
You are in an eligible class if:

- You are a regular full-time employee of Adobe Systems Incorporated participating in this plan working a minimum of 25 hours per week and you elected coverage under the plan.

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 domestic partner who meets the rules set by your employer; and
- Your dependent children; and
- Dependent children of your domestic partner.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.
Coverage for Domestic Partner
A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past six months.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she has cohabitated and resided with you in the same residence for the past six months and intends to cohabit and reside with you indefinitely.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
  - Common ownership of a motor vehicle;
  - Driver’s license listing a common address;
  - Proof of joint bank accounts or credit accounts;
  - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
  - Assignment of a durable property power of attorney or health care power of attorney.

Coverage for Dependent Children (GR-9N-29.010.66 DE)
To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child 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 this 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 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

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.

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

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

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

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

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

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

Special Enrollment Periods (GR-9N.29.015.05)
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 or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

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

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

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

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

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

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

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

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

If You Adopt a Child
Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.
Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan’s definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement;
- Proof of placement will need to be presented to Aetna prior to the dependent enrollment;
- Any coverage limitations for a preexisting 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 request coverage for the child in writing within 31 days of the court order.

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

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

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**

Your coverage takes effect on:

- The date you are eligible for coverage.

**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 Aetna within 31 days because they may affect your contributions. If you do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.
How Your Medical Plan Works

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

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

Important Notes

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

Common Terms

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

About Your PPO Comprehensive Medical Plan

This Preferred Provider Organization (PPO) insurance 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 PPO plan, you can directly access any physician, hospital or other health care provider (network, out-of-network or outside the United States) for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through network providers or out-of-network providers.

The plan will pay for covered expenses up to the maximum benefits shown in this Booklet-Certificate. Coverage is subject to all the terms, policies and procedures outlined in this Booklet-Certificate. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the What the Plan Covers, Exclusions, Limitations and Schedule of Benefits sections to determine if medical services are covered, excluded or limited.
This PPO plan provides access to covered benefits through a network of health care providers and facilities. These network providers have contracted with Aetna, an affiliate or third party vendor to provide health care services and supplies to Aetna plan members at a reduced fee called the negotiated charge. This PPO 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. However, such providers may not balance bill you for dental care charges over the amount Aetna pays under the plan for children under the age of 21 with a severe disability who, due to a significant mental or physical condition, illness, or disease, are likely to require specialized treatment or supports to secure effective access to dental care. This applies to dental care charges that would be considered a covered expense under Your PPO Medical Plan.

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

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

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

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

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

How Your PPO Plan Works (GR-9N-08-025-03 DE)

Accessing Network Providers and Benefits

- You may select any network provider from the Aetna network provider directory or by logging on to Aetna’s website www.aetnainternational.com. You can search Aetna's online directory, DocFind®, for names and locations of physicians and other health care providers and facilities. You can change your health care provider at any time.
- If a service you need is covered under the plan but not available from a network provider, please contact Member Services at the toll-free number on your ID card for assistance.
- Certain health care services obtained in the United States 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 is no additional out-of-pocket cost to you as a result of a network provider's failure to precertify services. Refer to the Understanding Precertification section for more information.
You will not have to submit medical claims for treatment received from network providers. Your network provider will take care of claim submission. Aetna will directly pay the network provider less any cost sharing required by you. You will be responsible for deductibles, coinsurance, and copayment, if any.

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

Cost Sharing For Network Benefits

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

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

For certain types of services and supplies, you will be responsible for any copayment shown in the Schedule of Benefits.

After you satisfy any applicable deductible, you will be responsible for your coinsurance for covered expenses that you incur. Your coinsurance is based on the negotiated charge. You will not have to pay any balance bills above the negotiated charge for that covered service or supply. You will be responsible for your coinsurance up to the maximum out-of-pocket limit applicable to your plan.

Once you satisfy any applicable 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 your Schedule of Benefits section for information on what specific limits, 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, copayments, or coinsurance amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits

You have the choice to directly access physicians, hospitals or other health care providers that do not participate with the Aetna provider network. You will still be covered when you access out-of-network providers for covered benefits. Your out-of-pocket costs will generally be higher.

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. However, such providers may not balance bill you for dental care charges over the amount Aetna pays under the plan for children under the age of 21 with a severe disability who, due to a significant mental or physical condition, illness, or disease, are likely to require specialized treatment or supports to secure effective access to dental care. This applies to dental care charges that would be considered a covered expense under Your PPO Medical Insurance Plan. Deductibles and coinsurance are usually higher when you utilize out-of-network providers. Except for emergency services, Aetna will only pay up to the recognized charge.

Precertification is necessary for certain services obtained in the United States. When you receive services from an out-of-network provider, you are responsible for obtaining the necessary precertification from Aetna. 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, the benefit payable may be significantly reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call the precertification toll-free number on your ID card to precertify services. Refer to the Understanding Precertification section for more information on the precertification process and what to do if your request for precertification is denied.
- When you use physicians and hospitals that are not in the network you may have to pay for services at the time they are rendered. You may be required to pay the charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of covered expenses you paid directly to an out-of-network provider. Aetna will reimburse you for a covered expense up to the recognized charge, less any cost sharing required by you.

- If your out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred above the recognized charge. The recognized charge is the maximum amount Aetna will pay for a covered expense from an out-of-network provider.

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

**Important Note**
Failure to precertify in the United States will result in a reduction of benefits under this Booklet-Certificate. Please refer to the Understanding Precertification section for information on how to precertify and the precertification benefit reduction.

**Cost Sharing for Out-of-Network Benefits**

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

- You must satisfy any deductibles before the plan begins to pay benefits.

- After you satisfy any applicable deductible, you will be responsible for any applicable coinsurance for covered expenses that you incur. You will be responsible for your coinsurance up to the maximum out-of-pocket limit applicable to your plan.

- Your coinsurance will be based on the recognized charge. If the health care provider you select charges more than the recognized charge, you will be responsible for any expenses above the recognized charge.

- Once you satisfy any applicable 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 and for the specific dollar limits 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 section. You are responsible for any expenses incurred over the maximum limits outlined in the What the Plan Covers or the Schedule of Benefits sections.

**Understanding Precertification** *(Applies in the United States)* (GR-9N-0806001)

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

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

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

**Important Note**
Please read the following sections in their entirety for important information on the precertification process, and any impact it may have on your coverage.
The Precertification Process
Prior to being hospitalized or receiving certain other medical services or supplies there are certain precertification procedures that must be followed.

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

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

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Timing Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>For non-emergency admissions:</td>
<td>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.</td>
</tr>
<tr>
<td>For an emergency outpatient medical condition:</td>
<td>You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.</td>
</tr>
<tr>
<td>For an emergency admission:</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>For an urgent admission:</td>
<td>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.</td>
</tr>
<tr>
<td>For outpatient non-emergency medical services requiring precertification:</td>
<td>You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
</tbody>
</table>

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

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

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

Services and Supplies Which Require Precertification (Applies in the United States) (GR-9N-08-065-04 DE)
Precertification is required for the following types of medical expenses:

**Inpatient and Outpatient Care**
- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Outpatient hospice care
- Stays in a residential treatment facility for treatment of mental disorders, alcoholism or drug abuse treatment
- Home health care
- Private duty nursing care
How Failure to Precertify Affects Your Benefits *(Applies in the United States) (GR.9N 08.07.01)*

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

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

**How Your Benefits are Affected**

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

<table>
<thead>
<tr>
<th>If <strong>precertification</strong> is:</th>
<th>then the expenses are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ requested and approved by <strong>Aetna</strong></td>
<td>▪ covered.</td>
</tr>
<tr>
<td>▪ requested and denied.</td>
<td>▪ not covered, may be appealed.</td>
</tr>
<tr>
<td>▪ not requested, but would have been covered if requested.</td>
<td>▪ covered after a <strong>precertification</strong> benefit reduction is applied.*</td>
</tr>
<tr>
<td>▪ not requested, would not have been covered if requested.</td>
<td>▪ not covered, may be appealed.</td>
</tr>
</tbody>
</table>

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 **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** *(GR.9N-27-005-01)*

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

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

**In Case of a Medical Emergency**

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

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **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 room for a non-emergency condition, your benefits may be reduced. Please refer to the *Schedule of Benefits* for specific details about the plan. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the plan.

**Coverage for Emergency Medical Conditions**

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

**Important Reminder**

If you visit a **hospital** emergency room for a non-emergency condition, the plan may 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 unless otherwise specified under the Plan.
In Case of an Urgent Condition (GR-9N-27-010-01)

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

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

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

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), your benefits may be reduced unless otherwise specified under the Plan. 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 may pay a reduced benefit, as shown in the Schedule of Benefits. No other plan benefits will pay for non-urgent care received at a hospital or an urgent care provider unless otherwise specified.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition
Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for illness or injury. If you access a hospital emergency room for follow-up care, your coverage may 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 network provider.

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

Important Notice
Follow-up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should not be provided by an emergency room facility.
Requirements for Coverage (GR-9N-09-005-01 DE)

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

1. The service or supply or prescription drug must be covered by the plan. For a service or supply or prescription drug to be covered, it must:

   - Be included as a covered expense in this Booklet-Certificate;
   - Not be an excluded expense under this Booklet-Certificate. Refer to the Exclusions sections of this Booklet-Certificate for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the What the Plan Covers section and the Schedule of Benefits for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.

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

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

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

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

**Important Note**

Not every service, supply or prescription drug 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

PPO Medical Plan

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

Preventive Care

This section on Preventive Care describes the covered expenses for services and supplies provided when you are well.

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 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 to age 18 also include:

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

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

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

Important Reminder

Refer to the Schedule of Benefits for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for physical exams.
Routine Cancer Screenings

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

- Mammograms for covered females;
- 1 Pap smear per Calendar Year;
- 1 gynecological exam per Calendar Year;
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test per Calendar Year for covered males age 40 and older.

The plan will cover cancer screenings prior to the age limits or more frequently when medically indicated and ordered by a physician.

Colorectal Cancer Screening

- For persons 50 years of age or older; or
- For persons who are deemed at high risk for colon cancer because of:
  a. Family history of familial adenomatous polyposis;
  b. Family history of hereditary nonpolyposis colon cancer;
  c. Chronic inflammatory bowel disease;
  d. Family history of breast, ovarian, endometrial, colon cancer or polyps; or
  e. A background, ethnicity or lifestyle such that the health care provider treating the participant or beneficiary believes he or she is at elevated risk;

Covered expenses include:

- one fecal occult blood test per 12 consecutive month period; and
- a flexible sigmoidoscopy every five years; and
- a colonoscopy (or virtual colonoscopy) every ten years;
- a double contrast barium enema every five years;
- radiologic imaging or other screening modalities, in appropriate circumstances, as determined by the Secretary of Health and Social Services of this State after consideration of recommendations of the Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending physician.

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 any 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.

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.

Lead Poisoning Screening for Children

Covered Medical Expenses include charges for a baseline lead poisoning screening for children at or around 12 months of age and also for children under the age of 6 years who are at high risk for lead poisoning, in accordance with the established guidelines and criteria.

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

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

- **Routine** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 24 consecutive month period.

Limitations

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

Hearing Exam (GR-9N:S-11-015-01)

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 any 24-month period.

All covered expenses for the hearing exam are subject to any applicable deductible, copay and coinsurance shown in your Schedule of Benefits.
Physician Services (GR 9N S 11-20 02)

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

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by 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 in the United States 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 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.

E-Visits (Applies in the United States as designated in DocFind)
Covered expenses include charges made by your physician for a routine, non-emergency, medical consultation. You must make your E-visit through an Aetna authorized internet E-visit service vendor. You may have to register with that internet E-visit service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.aetnainternational.com or by calling the number on your identification card.

Hospital Expenses (GR-9N/11-030 01)
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 (GR-9N-11-030 01)
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. The plan does not cover private duty nursing services as part of an inpatient hospital stay.

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

Hospital admissions in the United States 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 details about any applicable deductible, copay and coinsurance and maximum benefit limits.

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

The emergency care benefit covers:

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

Please contact a network provider after receiving treatment for an emergency medical condition.

Important Reminder
With the exception of Urgent Care described below, if you visit a hospital emergency room for a non-emergency condition, the plan may 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.
Coverage for Urgent Conditions
Covered expenses include charges made by a hospital or urgent care provider to evaluate and treat an urgent condition.

Your coverage includes:

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

Please contact a network provider after receiving treatment of an urgent condition.

If you visit an urgent care provider for a non-urgent condition, the plan may pay a reduced benefit, as shown in the Schedule of Benefits.

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

Outpatient Surgery and Physician Surgical Services
Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

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

The surgery must meet the following requirements:

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

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

The following outpatient surgery expenses are covered:

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

Limitations
Not covered under this plan are charges made for:

- The services of a physician or other health care provider who renders technical assistance to the operating physician.
- A stay in a hospital.
- Facility charges for office based surgery.
Birthing Center
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 (GR-9N-11-050-01)
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 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.
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 domestic partner's family.
- Services of a certified or licensed social worker.
- 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 in the United States 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.

Skilled Nursing Care
Covered expenses include charges by an R.N., L.P.N., or nursing agency for outpatient skilled nursing care.

This is care by a visiting R.N. or L.P.N. to perform specific skilled nursing tasks.

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

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

Skilled Nursing Facility (GR-9N-11-060-01)
Covered expenses include charges made by a skilled nursing facility during your stay for the following services and supplies, up to the maximums shown in the Schedule of Benefits, including:

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

You must meet the following conditions:

- You are currently receiving inpatient hospital care, or inpatient subacute care, and
- The skilled nursing facility admission will take the place of an admission to, or continued stay in, a hospital or subacute facility; or it will take the place of three or more skilled nursing care visits per week at home; and
- There is a reasonable expectation that your condition will improve sufficiently to permit discharge to your home within a reasonable amount of time; and
- The illness or injury is severe enough to require constant or frequent skilled nursing care on a 24-hour basis; and
- Your stay in a skilled nursing facility:
  - follows a hospital stay of at least three days in a row; and
  - begins within 14 days after your discharge from the hospital; and
  - is necessary to recover from the illness or injury that caused the hospital stay.

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

Admissions to a skilled nursing facility in the United States 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;
- Dietetic counseling; and
- Psychological counseling.

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

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

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

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

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

Inpatient hospice care and home health care in the United States must be precertified by Aetna. Refer to How the Plan Works for details about precertification.
Other Covered Health Care Expenses *(GR-9N-11-080-02 DE)*

**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.

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

**Ambulance Service** *(GR-9N 11-080 02)*
**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; or
- By fixed wing air ambulance from an out-of-network provider.
**Autism Spectrum Disorders**

Covered expenses include charges made by a physician or behavioral health provider for the services and supplies for the diagnosis and treatment (including behavioral therapy and Applied Behavioral Analysis) of Autism Spectrum Disorder when ordered by a physician as part of a Treatment Plan; and

- The covered child is diagnosed with Autism Spectrum Disorder with onset prior to age twenty-one; and
- The covered expenses are incurred prior to attainment of age twenty-one.

Applied Behavioral Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative
- Asperger's Syndrome; and
- Pervasive Developmental Disorder - Not Otherwise Specified.

**Diagnostic and Preoperative Testing** *(GR-9N-11-085-02)*

**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);
- Nuclear medicine imaging including positron emission tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service where the recognized charge exceeds $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, coinsurance and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.
Outpatient Preoperative Testing
Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a hospital, surgery center, physician or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the 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-Certificate. **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, coinsurance and benefit maximums. Also refer to **Exclusions** for information about Home and Mobility exclusions.
Clinical Trials

Clinical Trial Therapies (Experimental or Investigational)

Covered expenses include charges made for experimental or investigational drugs, devices, treatments or procedures “under an approved clinical trial” only when you have cancer or a terminal illness, and all of the following conditions are met:

- Standard therapies have not been effective or are inappropriate;
- Aetna determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets these criteria.

An “approved clinical trial” is a clinical trial that meets these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial 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 federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Routine Patient Costs

Covered expenses include charges made by a provider for “routine patient costs” furnished in connection with your participation in an “approved clinical trial” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

Limitations:
Not covered under this Plan are:

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs);
- Services and supplies provided by the trial sponsor without charge to you; and
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna’s claim policies).

Important Note:
1. Refer to the Schedule of Benefits for details about cost sharing and any benefit maximums that apply to the Clinical Trial benefit.
2. These Clinical Trial benefits are subject to all of the terms, conditions, provisions, limitations, and exclusions of this Plan including, but not limited to, any precertification and referral requirements.
Pregnancy Related Expenses (GR.9N-11-100.01)

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

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

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

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

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

Prescription Drugs

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

Orthotic and Prosthetic Devices

Covered expenses include charges made for orthotic devices and 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 orthotic device and prosthetic device. Reimbursement rates for orthotic and prosthetic devices will be at least equal to federal reimbursement rates provided for under federal laws for health insurance for the aged and disabled. "Federal reimbursement rates" means the current listed fee schedule from the Centers for Medicare and Medicaid Services, listing the current Healthcare Common Procedure Coding System (HCPCS) and the corresponding reimbursement rates. Covered expenses for orthosis and prosthesis include those items covered by Medicare unless excluded in the definitions below or in the Medical Benefit Exclusions section of this Certificate. Aetna reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. All maintenance and repairs that result from misuse or abuse and replacements that result from loss are not covered.

The plan covers the first orthosis and 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 an orthotic device and 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.

External "prosthesis" means an artificial limb that is alignable or, in lower-extremity applications, capable of weight bearing. External prosthesis means an artificial medical device that is not surgically implanted and that is used to replace a missing limb, appendage, or other external human body part including an artificial limb, hand, or foot. The term does not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

External "prosthetics" means the science and practice of evaluation, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, a prosthesis through the replacement of external parts of a human body lost due to amputation, congenital deformities, or abscesses. The practice of prosthetics also includes the generation of an image, form, or mold that replicates the patient's body or body segment and that requires rectification of dimensions, contours, and volumes for use in the design and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial appendage that is designed either to support body weight or to improve or restore function or cosmesis, or both. Involved in the practice of prosthetics is observational gait analysis and clinical assessment of the requirements necessary to refine and mechanically fix the relative position of various parts of the prosthesis to maximize function, stability, and safety of the patient. The practice of prosthetics includes providing and continuing patient care in order to assess the prosthetic device's effect on the patient's tissues and to assure proper fit and function of the prosthetic device through periodic evaluation.

"Orthosis" means a custom fabricated brace or support that is designed based on medical necessity. Orthosis does not include prefabricated or direct-formed orthotic devices or any of the following assistive technology devices: commercially available knee orthoses used following injury or surgery; spastic muscle-tone inhibiting orthoses; upper extremity adaptive equipment; finger splints; hand splints; wrist gauntlets; face masks used following burns; wheelchair seating that is an integral part of the wheelchair and not worn by the patient independent of the wheelchair; fabric or elastic supports; corsets; low-temperature formed plastic splints; trusses; elastic hose; canes; crutches; cervical collars; dental appliances; and any other similar devices, as determined by Secretary of the Department of Health and Social Services, commonly carried in stock by a pharmacy, department store, or surgical supply facility.

"Orthotics" means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, an orthosis for the support, correction, or alleviation of neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity. The practice of orthotics encompasses evaluation, treatment, and consultation; with basic observational gait and postural analysis, orthotists assess and design orthoses to maximize function and provide not only the support but also the alignment necessary to either prevent or correct a deformity or to improve the safety and efficiency of mobility, locomotion, or both. Orthotic practice includes providing continuing patient care in order to assess its effect on the patient's tissues and to assure proper fit and function of the orthotic device through periodic evaluation.
Limitations:
Unless specified above, not covered under this benefit are charges incurred for, or expenses related to:
- Services which are covered to any extent under any other part of this Plan;
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- Any item listed in the Prosthetic Devices Exclusions section of this Booklet-Certificate.

Scalp Hair Prosthesis
Coverage is provided for expenses for scalp hair prostheses worn for hair loss resulting from alopecia areata, resulting from an autoimmune disease. Coverage is subject to the same limitations and guidelines as other prostheses. Please see the Schedule of Benefits for any Copayments and limitations.

Hearing Aid Expenses
Coverage is provided for hearing aids, 1 per ear, every 3 years, for children less than 24 years of age, and covered as a dependent. Please see the Schedule of Benefits for any Copayments and limitations.

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.

Important Notice
A benefit maximum may apply to reconstructive or cosmetic surgery services. Please refer to the Schedule of Benefits.

Short-Term Rehabilitation Therapy Services
Covered expenses include 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; 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-Certificate.

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

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

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

**Important Reminder**
Refer to the Schedule of Benefits for details about the short-term rehabilitation therapy maximum benefit.
Unless specifically covered above, not covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate). 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 provided by a home health care agency;
- Services not performed by a physician or under the direct supervision of a physician;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a physician or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse’s family; or your domestic partner;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Specialized Care (GR-9N-11-135-05)

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 infusion therapy received from an outpatient setting including but not limited to:

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

The list of preferred infusion locations can be found by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

Certain infused medications may be covered under the prescription drug plan. You can access the list of specialty care prescription drugs by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the prescription drug plan or this certificate.
Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are covered expenses:

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

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

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

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

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

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

**Important Reminder**

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

**Specialty Care Prescription Drugs**

Covered expenses include specialty care prescription drugs when they are:

- Purchased by your provider, and
- Injected or infused by your provider in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a hospital
  - A physician in his/her office
  - A home care provider in your home
- And, listed on our specialty care prescription drug list as covered under this certificate.

Certain infused medications may be covered under the prescription drug plan. You can access the list of specialty care prescription drugs by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetmainternational.com or calling the number on the back of your ID card to determine if coverage is under the prescription drug plan or this certificate.
Diabetic Equipment, Supplies and Education

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

- External insulin pumps;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Treatment of Infertility (GR-9N 11-135.01)

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

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 (GR-9N 11-160.01)

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 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 in the United States 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;
- 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.
Treatment of Mental Disorders and Substance Abuse

Treatment of Mental Disorders

**Covered expenses** include charges made by a hospital, psychiatric hospital, residential treatment facility or behavioral health providers for the treatment of mental disorders as follows:

- **Inpatient room and board** at the semi-private room rate, and other services and supplies related to your condition that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility.

- **Outpatient treatment** received while not confined as an inpatient in a hospital, psychiatric hospital or residential treatment facility, including:
  - Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a physician. The facility or program does not make a room and board charge for the treatment.
  - Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program under the direction of a physician.
  - Office Visits to a physician (such as a psychiatrist), psychologist, social worker, or licensed professional counselor, as well as other health professionals.

**Important Notes:**

Please refer to the E-visits section for information about covered expenses for e-visits.

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

Inpatient care, partial hospitalizations and outpatient treatment in the United States must be precertified by Aetna. Refer to How the Plan Works for more information about precertification.

Please refer to the Schedule of Benefits for any copayments/deductibles, maximums, coinsurance limits that may apply to your mental disorders benefits.

Treatment of Substance Abuse

**Covered expenses** include charges made by a hospital, psychiatric hospital, residential treatment facility or behavioral health provider for the treatment of substance abuse as follows:

- **Inpatient room and board** at the semi-private room rate and other services and supplies that are provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Treatment of substance abuse in a general medical hospital is only covered only when you are admitted to the hospital's separate substance abuse section (or unit) for treatment of medical complications of substance abuse.

  As used here, “medical complications” include, but are not limited to, detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- **Outpatient treatment** received while not confined as an inpatient in a hospital, psychiatric hospital or residential treatment facility, including:
  - Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a physician. The facility or program does not make a room and board charge for the treatment.
- Intensive Outpatient Program (at least 2 hours per day and at least six hours per week of clinical treatment) provided in a facility or program under the direction of a **physician**.

- Ambulatory detoxification – Outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications.

- Office visits to a **physician** (such as a **psychiatrist**), psychologist, social worker, or licensed professional counselor, as well as other health care professionals.

**Important Notes:**

Please refer to the **E-visits** section for information about **covered expenses** for e-visits.

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

Inpatient treatment and certain outpatient treatments in the United States must be **precertified** by **Aetna**. Refer to the **How the Plan Works** section for details.

Please refer to the **Schedule of Benefits** for any **copayments/deductibles**, maximums and coinsurance limits that may apply to your **substance abuse** benefits.

**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 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.

**Coverage for Medical Formula or Food Products for the Treatment of PKU and Inherited Metabolic Diseases**

Coverage is included for medical formulas and foods, low protein modified formulas and modified food products for the treatment of inherited metabolic diseases, if such medical formulas and foods or low protein modified formulas and food products are:

- prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic disease, and are:
- administered under the direction of a Physician.

In this section, the following words shall have the meanings indicated:

“Inherited metabolic diseases” shall mean diseases caused by an inherited abnormality of biochemistry. The words "inherited metabolic diseases" shall also include any diseases for which the State screens newborn babies.

"Low protein modified formula or food product" means a formula or food product that is:

- specially formulated to have less than one (1) gram of protein per serving; and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.
- low protein modified formula or food product that does not include a natural food that is naturally low in protein.

"Medical formula or food" means a formula or food that is:

- intended for the dietary treatment of an inherited metabolic disease for which nutritional requirements and restrictions have been established by medical research; and
- formulated to be consumed or administered enterally under the direction of a Physician.

The deductible, if any, will not apply to the coverage for medical formula or food products for the treatment of PKU and inherited metabolic diseases.

**Medical Plan Exclusions (GR-9N-28.015-07)**

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

**Important Note:**
You have medical and prescription drug insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific prescription drug coverage. Those additional exclusions are listed separately under the What The Plan Covers section for each of these benefits.

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 (Rinkel 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-Certificate.
Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain prescription drugs or supplies, even if otherwise covered under this Booklet-Certificate. This also includes prescription drugs or supplies if:

- such prescription drugs or supplies are unavailable or illegal in the United States; or
- the purchase of such prescription drugs or supplies outside the United States is considered illegal.

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

Behavioral Health Services:

- Alcoholism or substance abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for detoxification or treatment of alcoholism or substance abuse is specifically provided in the What the Medical Plan Covers Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the What the Plan Covers section of this Booklet-Certificate.

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 for a service or supply furnished by a network provider in excess of the negotiated charge.

Charges for a service of supply furnished by an out-of-network provider in excess of the recognized charge.

Charges submitted for services that are not rendered, or 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;
- 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);
- Removal of tattoos;
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation; and
- Otoplasty.
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, removal of bony impacted teeth, 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.

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;
- Injectable drugs if an alternative oral drug is available;
- Any prescription drugs, injectables, or medications or supplies provided by the policyholder or through a third party vendor contract with the policyholder; 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;
- 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;
  - by any law of a government;
  - for securing insurance, school admissions or professional or other licenses;
  - to travel;
  - to 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.

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

**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 individual's 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. This exclusion does not apply to specialized medical foods delivered enterally (only when delivered via a tube directly into the stomach or intestines) or parenterally.

Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- 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), foot orthotics, 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 (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

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;
- Replacement parts or repairs for a hearing aid; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except otherwise provided under the *What the Plan Covers* section.
Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- 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, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, 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 alterations 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 alterations 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.

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;
- Artificial Insemination;
- Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- Any charges associated with care required to obtain ART Services (e.g., office, hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.
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.

Prosthetics or prosthetic devices unless specifically covered under What the Plan Covers Section.

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, domestic 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.

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-Certificate.

Services that are not covered under this Booklet-Certificate.

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

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.

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:

- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- 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-Certificate, 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 illness or injury that arises 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.
Your Pharmacy Benefit

How the Pharmacy Plan Works

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

- Definitions you need to know;
- How to access network pharmacies and procedures you need to follow;
- What prescription drug expenses are covered and what limits may apply;
- What prescription drug expenses are not covered by the plan;
- How you share the cost of your covered prescription drug expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

A few important notes to consider before moving forward:

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

Notice

The plan does not cover all prescription drugs, medications and supplies. Refer to the Limitations section of this coverage and Exclusions section of your Booklet-Certificate.

- Covered expenses are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage and in your Schedule of Benefits.
- Injectable prescription drug refills will only be covered when obtained through Aetna’s specialty pharmacy network.

Getting Started: Common Terms

You will find the terms below used throughout this Booklet-Certificate. They are described within the sections that follow, and you can also refer to the Glossary at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the Glossary.

Brand-Named Prescription Drug is a prescription drug with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by Aetna.

Generic Prescription Drug is a prescription drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient. These drugs are identified by Medispan or any other publication designated by Aetna.

Network pharmacy is a description of a retail, mail order or specialty pharmacy that has entered into a contractual agreement with Aetna, an affiliate, or a third party vendor, for the provision of covered services to you and your covered dependents. The appropriate pharmacy type may also be substituted for the word pharmacy. (E.g. network retail pharmacy, network mail order pharmacy or specialty pharmacy network).
Non-Preferred Drug (Non-Formulary) is a brand-named prescription drug or generic prescription drug that does not appear on the preferred drug guide.

Out-of-network pharmacy is a description of a pharmacy that has not contracted with Aetna, an affiliate, or a third party vendor, and does not participate in the pharmacy network.

Preferred Drug (Formulary) is a brand-named prescription drug or generic prescription drug that appears on the preferred drug guide.

Preferred Drug Guide is a listing of prescription drugs established by Aetna or an affiliate, which includes both brand-named prescription drugs and generic prescription drugs. This list is subject to periodic review and changes by Aetna. A copy of the preferred drug guide will be available upon your request or may be accessed on the Aetna website at www.aetna.com/formulary.

Preferred Drug Guide Exclusion List is a list of prescription drugs in the Preferred Drug Guide that are identified as excluded under the plan. This list is subject to periodic review and modification by Aetna.

Prescription Drug is a drug, biological, or compounded prescription which, by State or Federal Law, may be dispensed only by prescription and which is required by Federal Law to be labeled “Caution: Federal Law prohibits dispensing without prescription.” This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

Provider is any recognized health care professional, pharmacy or facility providing services with the scope of their license.

Self-injectable Drug(s). Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

Specialty Pharmacy Network. Aetna’s network of participating pharmacies designated to fill Self-injectable Drug prescriptions.

Accessing Pharmacies and Benefits (GR-9N-12-015-07)

This plan provides access to covered benefits through a network of pharmacies, vendors or suppliers. Aetna has contracted for these network pharmacies to provide prescription drugs and other supplies to you.

Obtaining your benefits through network pharmacies has many advantages. Benefits and cost sharing may also vary by the type of network pharmacy where you obtain your prescription drug and whether or not you purchase a brand-name or generic drug. Network pharmacies include retail, mail order and specialty pharmacies.

Accessing Network Pharmacies and Benefits
You may select a network pharmacy from Aetna’s on-line provider directory which can be found at www.aetnainternational.com. You can search Aetna’s online directory, DocFind, for names and locations of network pharmacies. If you cannot locate a network pharmacy in your area, call Member Services at the number on your ID card.

You must present your ID card to the network pharmacy every time you get a prescription filled to be eligible for network pharmacy benefits. The network pharmacy will calculate your claim online. You will pay any deductible, copayment or coinsurance directly to the network pharmacy. You do not have to complete or submit claim forms. The network pharmacy will take care of claim submission.
Emergency Prescriptions
When you need a prescription filled in an emergency or urgent care situation, or when you are traveling, you can obtain network pharmacy benefits by filling your prescription at any network pharmacy in the United States. The network pharmacy will fill your prescription and only charge you your plan’s cost sharing amount.

Coverage for prescription drugs obtained from an out-of-network pharmacy is limited to those obtained in connection with emergency and out-of-area urgent care services.

Availability of Providers
Aetna cannot guarantee the availability or continued network participation of a particular pharmacy. Either Aetna or any network pharmacy may terminate the provider contract.

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

- You will be responsible for the copayment for each prescription or refill as specified in the Schedule of Benefits. The copayment is payable directly to the network pharmacy at the time the prescription is dispensed.
- After you pay the applicable copayment, you will be responsible for any applicable coinsurance for covered expenses that you incur. Your coinsurance amount is determined by applying the applicable coinsurance percentage to the negotiated charge if the prescription is filled at a network pharmacy. When you obtain your prescription drugs through a network pharmacy, you will not be subject to balance billing.

When You Use an Out-of-Network Pharmacy (GR-9N 13-003 01 DE)
You can directly access an out-of-network pharmacy to obtain covered outpatient prescription drugs. You will pay the pharmacy for your prescription drugs at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of covered expenses you paid directly to an out-of-network pharmacy. Aetna will reimburse you for a covered expense up to the recognized charge, less any cost sharing required by you.

Cost Sharing for Out-of-Network Benefits
You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

Out-of-network expenses will be reimbursed by your medical expense coverage. You will be subject to the cost sharing provisions listed in the Schedule of Benefits for your medical expense coverage.

Pharmacy Benefit (GR-9N 13-006-02)
What the Plan Covers
The plan covers charges for medically necessary outpatient prescription drugs for the treatment of an illness or injury, subject to the Prescription Drug Limitations section below and the Exclusions section of the Booklet-Certificate. Prescriptions must be written by a prescriber licensed to prescribe federal legend prescription drugs.

Preferred generic prescription drugs may be substituted by your pharmacist for brand-name prescription drugs. You may minimize your out-of-pocket expenses by selecting a generic prescription drug when available.

Coverage of prescription drugs may, in Aetna’s sole discretion, be subject to Aetna requirements or limitations. Prescription drugs covered by this plan are subject to drug and narcotic utilization review by Aetna, your provider and/or your network pharmacy. This may include limiting access of prescription drugs prescribed by a specific provider. Such limitation may be enforced in the event that Aetna identifies an unusual pattern of claims for covered expenses.
The plan does not cover charges for prescription drugs listed on formulary exclusions list. Drugs on the formulary exclusions list are excluded from coverage unless a medical exception for coverage is obtained. If it is medically necessary for you to use a prescription drug on the formulary exclusions list, the prescriber who prescribed the drug must request coverage as a medical exception. Refer to the Medical Exceptions description under precertification for information on how your prescriber can obtain a medical exception for your prescription if necessary.

Prescription drugs listed in the formulary exclusions list in the preferred drug guide unless a medical exception has been obtained.

Coverage for prescription drugs and supplies is limited to the supply limits as described below.

**Retail Pharmacy Benefits**
Outpatient prescription drugs are covered when dispensed by a network retail pharmacy. Each prescription is limited to a maximum 365 day supply when filled at a network retail pharmacy.

**Mail Order Pharmacy Benefits**
Outpatient prescription drugs are covered when dispensed by a network mail order pharmacy. Each prescription is limited to a maximum 365 day supply. Prescriptions for less than a 31 day supply or more than a 365 day supply are not eligible for coverage when dispensed by a network mail order pharmacy.

**Other Covered Expenses**
The following prescription drugs, medications and supplies are also covered expenses under this Coverage.

**Off-Label Use (GR-9N 13-005 01 DE)**
FDA approved prescription drugs may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in Aetna's sole discretion, be subject to Aetna requirements or limitations.

**Diabetic Supplies (GR-9N 13-012 02)**
Covered expenses include but are not limited to the following diabetic supplies upon prescription by a Prescriber:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

**Contraceptives**
The following contraceptives and contraceptive devices:

- Oral Contraceptives.
- Diaphragms, 1 per 365 consecutive day period
- Injectable contraceptives.
- Contraceptive patches.
- Contraceptive rings.
- Implantable contraceptives and IUDs are covered when obtained from a physician. The physician will provide insertion and removal of the drugs or device.

**Oral Infertility Drugs**
The following prescription drugs used for the purpose of treating infertility including, but not limited to:

- Progesterone.
Preventive Care Drugs and Supplements

Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a network pharmacy. They are covered when they are:

- prescribed by a physician;
- obtained at a pharmacy; and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this Plan include, but may not be limited to:

- Aspirin: Benefits are available to adults.
- Oral Fluoride Supplements: Benefits are available to children whose primary water source is deficient in fluoride.
- Folic Acid Supplements: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- Iron Supplements: Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- Vitamin D Supplements: Benefits are available to adults to promote calcium absorption and bone growth in their bodies.
- Risk-Reducing Breast Cancer Prescription Drugs: Covered medical expenses include charges incurred for generic prescription drugs prescribed by a physician for a woman who is at increased risk for breast cancer and is at low risk for adverse medication side effects.

Coverage of preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

Important Note:

For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website www.aetnainternational.com and Aetna Navigator, or calling the number on the back of your ID card.

Tobacco Cessation Prescription and Over-the-Counter Drugs

Covered expenses include FDA-approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.

Refer to the Schedule of Benefits for the cost-sharing and supply limits that apply to these benefits.

Pharmacy Benefit Limitations (GR-9N 13-015 07)

A network pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any prescription drug for which the actual charge to you is less than the required copayment or deductible, or for any prescription drug for which no charge is made to you.

You will be charged the out-of-network prescription drug cost sharing for prescription drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet-Certificate.

Aetna reserves the right to include only one manufacturer’s product on the preferred drug list when the same or similar drug (that, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.
Aetna reserves the right to include only one dosage or form of a drug on the preferred drug list when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our preferred drug list will be covered at the applicable copayment or coinsurance.

The number of copayments/deductibles you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any prescription drug dispensed by a mail order pharmacy for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

Some prescription drugs are subject to quantity limits. These quantity limits help your prescriber and pharmacist check that your prescription drug is used correctly and safely. Aetna relies on medical guidelines, FDA-approved recommendations from drug makers and other criteria developed by Aetna to set these quantity limits. The quantity limit may restrict either the amount dispensed per prescription order or refill.

Depending on the form and packing of the product, some prescription drugs are limited to a single commercially prepackaged item excluding insulin, diabetic supplies, test strips dispensed per prescription order or refill.

Depending on the form and packing of the product, some prescription drugs are limited to 100 units excluding insulin dispensed per prescription order or refill.

Any prescription drug that has duration of action extending beyond one (1) month shall require the number of copayments per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) copayments.

Specialty care prescription drugs may have limited access or distribution and are subject to supply limits.

Plan approved blood glucose meters, asthma holding chambers and peak flow meters are eligible health services, but are limited to one (1) prescription order per contract year.

Pharmacy Benefit Exclusions (GR-9N 28-020 10 DE)
Not every health care service or supply is covered by the plan. Even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What the Plan Covers section or by amendment attached to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These prescription drug exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

Abortion drugs.

Administration or injection of any drug.

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

Allergy sera and extracts.
Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Booklet-Certificate. This also includes prescription drugs or supplies if:

- Such drugs or supplies are unavailable or illegal in the United States, or
- The purchase of such prescription drugs or supplies outside the United States is considered illegal.

Any drugs or medications, services and supplies that are not medically necessary, as determined by Aetna, for the diagnosis, care or treatment of the illness or injury involved. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

Contraceptive prescription drugs, devices, services and supplies (except as specifically described in the Preventive Care Benefits and Additional Covered Expenses section) including:

- Services associated with the prescribing, monitoring and/or administration of prescription drug contraceptives and devices.
- Female contraceptives that are brand-name prescription drugs; and
- FDA- approved female brand-name emergency contraceptives.

Contraception – Male condoms.

Cosmetic drugs, medications or preparations used for cosmetic purposes or to promote hair growth and removal, including but not limited to:

- health and beauty aids;
- chemical peels;
- dermabrasion;
- treatments;
- bleaching;
- creams;
- ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

Compounded prescriptions.

Devices and appliances that do not have the National Drug Code (NDC).

Dietary supplements including medical foods.

Drugs administered or entirely consumed at the time and place it is prescribed or dispensed.

Drugs for which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient.

Drugs which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written (except as specifically covered in the What the Pharmacy Plan Covers section.

Drugs provided by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.
Drugs that include vitamins and minerals, both over-the-counter (OTC) and legend, except legend pre-natal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium and legend vitamins that are medically necessary for the treatment of renal disease, hyperparathyroidism or other covered conditions with prior approval from us unless recommended by the United States Preventive Services Task Force (USPSTF).

Drugs used for methadone maintenance medications used for drug detoxification.

Drugs used for the purpose of weight gain or reduction, including but not limited to:

- stimulants;
- preparations;
- foods or diet supplements;
- dietary regimens and supplements;
- food or food supplements;
- appetite suppressants; and
- other medications.

Drugs used for the treatment of obesity.

Drugs used for the treatment of sexual dysfunction/enhancement.

All drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies.

Drugs or medications that include the same active ingredient or a modified version of an active ingredient.

Drug or medication that is therapeutically equivalent or therapeutically alternative to a covered prescription drug.

Drug or medication that is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product.

Duplicative drug therapy (e.g. two antihistamine drugs).

**Durable medical equipment**, monitors and other equipment.

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

This exclusion will **not** apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the illness.

Food items: Any food item, including:

- infant formulas;
- nutritional supplements;
- vitamins;
- medical foods and other nutritional items, even if it is the sole source of nutrition.

Genetics: Any treatment, device, drug, or supply to alter the body’s genes, genetic make-up, or the expression of the body’s genes except for the correction of congenital birth defects.

Immunization or immunological agents.

Implantable drugs and associated devices.
Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by Aetna;
- Injectable drugs dispensed by **out-of-network pharmacies**;
- Needles and syringes, except for diabetic needles and syringes;
- Injectable drugs if an alternative oral drug is available;
- For any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

**Prescription drugs** for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

**Prescription drugs**, medications, injectables or supplies given through a third party vendor contract with the policyholder.

**Prescription drugs** listed in the **formulary exclusions** list in the **preferred drug guide** unless a medical exception has been obtained.

**Prescription drugs** dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.

**Prescription drugs** that include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is no clinically superior to that drug as determined by the plan.

**Prescription drugs** that are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition.

**Prescription drugs** that are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.

**Prescription drugs** that are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

**Prescription orders** filled prior to the effective date or after the termination date of coverage under this Booklet-Certificate.

Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement.

Prophylactic drugs for travel.

Refills over the amount specified by the **prescription order**. Before recognizing charges, Aetna may require a new **prescription** or proof as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription order** was written, or as otherwise allowed by applicable law of the jurisdiction in which the drug is dispensed.
Replacement of lost or stolen prescriptions.

Drugs, services and supplies given in connection with treatment of an occupational injury or occupational illness.

Strength and performance: Drugs or preparations, devices or supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

Supplies, devices or equipment of any type, except as specifically provided in the What the Plan Covers section.

Test agents except diabetic test agents.

**When Coverage Ends (GR:9N:30.005.05 DE)**

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

**When Coverage Ends for Employees**

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, Aetna may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not actively at work due to illness or injury, your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

It is your employer’s responsibility to let Aetna know when your employment ends. The limits above may be extended only if Aetna and your employer agree, in writing, to extend them.

**Your Proof of Prior Medical Coverage (GR:9N:30.010.01)**

Under the Health Insurance Portability and Accountability Act of 1996, your employer is required to give you a certificate of creditable coverage when your employment ends. This certificate proves that you were covered under this plan when you were employed. Ask your employer about the certificate of creditable coverage.
When Coverage Ends for Dependents
Coverage for your dependents will end if:

- You are no longer eligible for dependents’ coverage;
- You do not make your contribution for the cost of dependents’ coverage;
- Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan’s definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

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

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See Continuation of Coverage for more information.
Continuation of Coverage

Continuing Health Care Benefits

Continuing Coverage for Dependent Students on Medical Leave of Absence

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious illness or injury, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. Aetna may require a written certification from the treating physician which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or change in full-time student status) is medically necessary.

Important Note

If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, Handicapped Dependent Children, for more information.

Delaware Continuation Rights for Over-Age Dependents

As used in this provision, “Over-Age Dependent” means an employee’s child by blood or law who:

- has reached the limiting age as described in the Dependent Eligibility section of the Summary of Benefits, but is less than 24 years of age;
- is not married;
- has no dependents of his or her own;
- is either a resident of Delaware or is enrolled as a full-time student at an accredited public or private institution of higher education; and
- is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, or church plan, or entitled to benefits under Medicare.
If a Dependent Loses Eligibility

If a dependent child’s group health benefits end or have ended due to his or her reaching the limiting age requirement in the Dependent Eligibility section of the Summary of Benefits, he or she may elect to continue such benefits until his or her 24th birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections as shown below.

Conditions for Election

An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met:

a) The group plan under which the dependent child was covered immediately prior to reaching the limiting age, as described in the Dependent Eligibility section under the group plan, must have been a fully-insured group plan issued in Delaware.

b) The dependent child must actually have been covered under the group plan on the date he or she reached the limiting age as described in the Dependent Eligibility section under the group plan.

c) The employee of an Over-Age Dependent must be enrolled as having elected dependent coverage at the time the Over-Age Dependent elects to continue coverage.

Election of Continuation

To continue group health benefits, an Over-Age Dependent, whose coverage under the plan terminated due to reaching the limiting age before the dependent’s 24th birthday, may make a written election for coverage as follows:

a) within 30 days prior to the termination of coverage at the specific age provided in the contract’s language;

b) within 30 days after meeting the requirements for an Over-Age Dependent, when coverage for the dependent under the group plan had previously terminated; or

c) during an open enrollment period, as provided pursuant to the group plan, if the Over-Age Dependent meets the requirements for dependent status as set forth in the dependent eligibility section under the group plan, during the open enrollment period.

In addition, adult children who reached the limiting age under the parent’s coverage prior to June 1, 2007 may make an enrollment request at any time from June 1, 2007 through May 31, 2008.

The Continued Coverage

The continued coverage shall be identical to the coverage provided to the Over-Age Dependent’s parent who is covered as an employee under the plan. If coverage is modified for dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends

An Over-Age Dependent’s continued group health benefits end on the first of the following:

a) the date the Over-Age Dependent:
   1. attains age 24;
   2. marries;
   3. acquires a dependent;
   4. is no longer either a resident of Delaware or enrolled as a full-time student at an accredited public or private institution of higher education; or
   5. becomes covered under any other group or individual health benefits plan, group health plan, or church plan, or becomes entitled to Medicare.

b) the date on which coverage ceases under the contract by reason of a failure to make a timely payment of any premium required under the contract by the covered person or dependent for Over-Age Dependent coverage;

c) the date the plan ceases to provide coverage to the Over-Age Dependent’s parent who is the employee under the plan.
d) The date the plan under which the Over-Age Dependent elected to continue coverage is amended to eliminate coverage for dependents.

e) The date the Over-Age Dependent’s parent who is covered as an employee under the plan waives dependent coverage. Except, if the employee has no other dependents, the Over-Age Dependent’s coverage will not end as a result of the employee waiving dependent coverage.

**Important Note:**

- Once the employer has validated the employee is an active employee and covered under the plan, the Supplemental Enrollment Information Form must be completed by the enrollee and submitted to Aetna according to the timeframes identified in the “Election of Continuation” section shown above.
- An Over-Age Dependent while being issued continued coverage as an Over-Age Dependent is not considered to be an employee.
- Aetna will bill the covered Over-Age Dependent directly and enrollees will remit the premium directly to Aetna. Enrollees will be required to enter an address on the Supplemental Enrollment Information Form even when it is the same as the employees address.
- Although the employee must continue eligibility under the group plan for continued coverage of the dependent, the dependent must also meet the applicable eligibility criteria. All cost sharing requirements and limitations will apply, and will not be aggregated with the employee’s plan. Consequently, Covered Benefits incurred by the dependent will not contribute towards the family deductible and Out-of-Pocket Maximums, nor will family incurred expenses contribute towards the Over-Age Dependent’s deductibles or Out-of-Pocket Maximums.
- Any deductible or Out-of-Pocket Maximums that the Over-Age Dependent satisfied as a Dependent under the group plan will not be used to satisfy the applicable deductible or Out-of-Pocket Maximum cost sharing for the continued coverage for the Over-Age Dependent. The Over-Age Dependent will need to satisfy any applicable deductible and Out-of-Pocket Maximum under the Over-Age Dependent Continuation of Coverage.
- The Termination of Coverage section of the Booklet-Certificate does not apply to an Over-Age Dependent. The Over-Age Dependent should refer to the Delaware Continuation Rights for Over-Age Dependents and the section titled “When Continuation Ends.”
- Over-Age Dependents who have made an Election for Continuation and whose coverage is later terminated under the Delaware Continuation Rights for Over-Age Dependents may not be eligible for the continuation provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or Delaware Continuation under the group plan.
- The Dependent Eligibility section in the group Summary of Benefits does not apply to the Over-Age Dependent. The first provision in the Delaware Continuation Rights for Over-Age Dependents above, defines an Over-Age Dependent eligibility.
- A dependent of an Over-Age Dependent will not be covered for any Covered Benefits in the Booklet-Certificate. This would also include any newborn children.
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 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

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

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

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

Coverage for Health Benefits

If your health benefits end while you are totally disabled, your health expenses will be extended as described below, but, with respect to medical benefits, only as to expenses incurred in connection with the injury or illness that caused the total disability. To find out why and when your coverage may end, please refer to When Coverage Ends.

“Totally disabled” means that because of an injury or illness:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage (GR-9N 31-020 01)

Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

Prescription Drug Benefits: Coverage will be available while you are totally disabled for up to 12 months.

When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)
COBRA Continuation of Coverage

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

Continuing Coverage through COBRA
When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer’s notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

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

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

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Disability May Increase Maximum Continuation to 29 Months
*If You or Your Covered Dependents Are Disabled.*

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

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

*If There Are Multiple Qualifying Events.*

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

**Determining Your Premium Payments for Continuation Coverage**

Your premium payments are regulated by law, based on the following:

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

**When You Acquire a Dependent During a Continuation Period**

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

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

**Important Note**

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

**When Your COBRA Continuation Coverage Ends**

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

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

(GR.9N-33.003-02)

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. “Plan” and “This plan” are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.
Which Plan Pays First (GR-9N-33-010-01)

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

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      i. The parents are married or living together whether or not married;
      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   B. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child’s health care expenses, but that parent’s spouse does, the plan of the parent’s spouse is the primary plan.
   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
      – The plan of the custodial parent;
      – The plan of the spouse of the custodial parent;
      – The plan of the noncustodial parent; and then
      – The plan of the spouse of the noncustodial parent.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, or subscriber longer is primary.
6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works

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

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of This Plan, the amount normally reimbursed for covered benefits or expenses under This Plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under This Plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of This Plan and another plan both agree that This Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

You are eligible for Medicare if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease.

If you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, the plan is the primary payor, which means that the plan pays benefits before Medicare pays benefits. Under other circumstances, the plan is the secondary payor, and pays benefits after Medicare.

### Which Plan Pays First

The plan is the primary payor when your coverage for the plan’s benefits is based on current employment with your employer. The plan will act as the primary payor for the Medicare beneficiary who is eligible for Medicare:

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

The plan is the secondary payor in all other circumstances.

### How Coordination With Medicare Works

#### When the Plan is Primary

The plan pays benefits first when it is the primary payor. You may then submit your claim to Medicare for consideration.

#### When Medicare is Primary

Your health care expense must be considered for payment by Medicare first. You may then submit the expense to Aetna for consideration.

Aetna will calculate the benefits the plan would pay in the absence of Medicare:

The amount will be reduced so that when combined with the amount paid by Medicare, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total allowable expense.
This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under Medicare will be applied under the plan in the order received by Aetna. Aetna will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

**Right to Receive and Release Required Information (GR.9N.S-33-025-01)**

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under This Plan and other plans. Aetna has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.
General Provisions

Type of Coverage

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

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will also include the right and opportunity to make an autopsy in the case of death where it is not prohibited by law. This will be done at no cost to you.

Legal Action

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

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

Confidentiality

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

Additional Provisions

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- 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 policy. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or Aetna.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.
Assignments (GR-9N 32-005 02 DE)

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

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

Misstatements (GR-9N-32-005-03)

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

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

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

Incontestability

As to Accident and Health Benefits:

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

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

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

If this plan pays benefits under this Booklet-Certificate to you for expenses incurred due to Third Party Injuries, then Aetna retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are 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 your 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.

**Workers’ Compensation**

If benefits are paid by Aetna and Aetna determines you received Workers’ 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 Workers’ 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 Workers’ Compensation due to medical or health care is not agreed upon or defined by you or the Workers’ Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers’ Compensation settlement or compromise.

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

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

**Recovery of Overpayments** *(GR-9N-32-015-01 DE)*

**Health Coverage**

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

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

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

**Reporting of Claims** *(GR-9N-32-020-01 DE) (GR-9N-32-015-01 DE)*

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

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.
If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. 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 (GR-9N-32-025-02)**

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.

Any unpaid balance will be paid within 30 days of receipt by Aetna of the due written proof.

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

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

**Records of Expenses (GR-9N-32-030-02)**

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

Very important are:

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

**Contacting Aetna**

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

Aetna Life Insurance Company  
Attention: Aetna International  
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.aetniainternational.com](http://www.aetniainternational.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 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when Aetna gives its written consent.

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

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

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

Effect of Prior Coverage - Transferred Business

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

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

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

coverage under any Major or Comprehensive Medical Expense Coverage section of this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided under the section, Continuing Coverage for Dependent Students on Medical Leave of Absence.
Discount Programs (GR-9N 32.045-01)

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 healthy 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 (GR-9N 32.045-01)
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.
Appeals Procedure (GR-9N-32-050-01 DE)

Definitions

Adverse Benefit Determination (Decision): 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.
- 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.
- A decision that the service or supply is not medically necessary.

An adverse benefit determination also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

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

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

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

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

External Review: A review of an adverse benefit determination or a final adverse benefit determination by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner and made up of physicians or other appropriate health care providers. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An adverse benefit determination that has been upheld by Aetna at the exhaustion of the appeals process.

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:

- Seriously jeopardize your life or health;
- 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.

Full and Fair Review of Claim Determinations and Appeals

As to medical and prescription drug claims and appeals only, Aetna will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the final adverse benefit determination is required to be provided so that you may respond prior to that date.
Prior to issuing a final adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of final adverse determination is required.

**Claim Determinations**

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and prescription drug claims only, if Aetna makes an adverse benefit determination, written notice will be provided to you, or in the case of a concurrent care claim, to your provider.

**Urgent Care Claims**

Aetna will notify you of an urgent care claim decision as soon as possible, but not later than 72 hours after the claim is made.

If more information is needed to make an urgent claim decision, Aetna will notify the claimant within 72 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 to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the physician to provide Aetna with the information.

**Pre-Service Claims**

Aetna will notify you of a pre-service claim decision as soon as possible, but not later than 15 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar day claim decision 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 day period. If this extension is needed because Aetna needs more information to make a claim decision, 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 notify you of a post-service claim decision as soon as possible, but not later than 30 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim decision 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 more information to make a claim decision, 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 notify you of a claim decision for urgent care as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 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 notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal.

If you file an appeal, coverage under the plan will continue for the previously approved course of treatment until a final appeal decision is rendered. During this continuation period, you are responsible for any copayments; coinsurance; and deductibles; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under appeal. If Aetna’s initial claim decision is upheld in the final appeal decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.
Complaints
If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Member Services. The complaint 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 more 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 depending upon the type of coverage provided under the Plan. A final adverse benefit determination notice will also provide an option to request an External Review (if available).

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an adverse benefit determination to request your Level One Appeal. Your appeal may be submitted orally or in writing and must include:

- Your name.
- The employer's name.
- A copy of Aetna's notice of an adverse benefit determination.
- Your reasons for making the appeal.
- Any other information you would like to have considered.

Send your written appeal to Member Services at the address shown on your ID Card, or call in your appeal to Member Services using the telephone number shown on your ID card.

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

You may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Level One Appeal
A review of a Level One Appeal of an adverse benefit determination shall be provided by Aetna personnel. They shall not have been 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 22 calendar days of receipt of the request for an appeal.

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

Review of 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. They shall not have been 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 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 a Level Two Appeal.

Post-Service Claims
Aetna shall issue a decision within 23 calendar days of receipt of the request for a Level Two Appeal.

Aetna may extend the Utilization Management Appeal review for up to an additional thirty (30) calendar days for reasonable cause by submitting a written explanation for the delay to the Delaware Department of Insurance within the original thirty (30) calendar review period. In no event, may Aetna extend the review period for an Urgent Care Claim or Concurrent Care Claim Extension.

In the event Aetna fails to comply with any of the above Level 1 or Level 2 Utilization Management Appeal timeframes, or in the event Aetna waives its rights to review an Utilization Management Appeal, you shall be relieved of your obligation to complete the two levels of Utilization Management Appeal, and at your option, may proceed directly to the External Utilization Management Appeal process.

You and/or an authorized representative may attend the Level Two Appeal hearing and question the representative of Aetna and/or any other witnesses, and present their case. Aetna shall acknowledge receipt of all Level 2 Utilization Management Appeals in writing to you. This acknowledgement shall include the place, date and time of the Level 2 Appeal hearing and provide you with at least fifteen (15) calendar days notice of the Level 2 Appeal hearing. You may request a change in the hearing schedule to facilitate attendance. The hearing will be informal. Your physician or other experts may testify. Aetna also has the right to present witnesses.

Exhaustion of Process
You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- Contact the Delaware Department of Insurance to request an investigation of a complaint or appeal; or
- File a complaint or appeal with the Delaware Department of Insurance; or
- Establish any:
  - Litigation;
  - Arbitration; or
  - Administrative proceeding;
regarding an alleged breach of the policy terms by Aetna or any matter within the scope of the Appeals Procedure.

Under certain circumstances, you may seek simultaneous review through the internal Appeals Procedure and External Review processes—these include Urgent Care Claims and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:
If Aetna does not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the appeal requirements and may proceed with External Review or any of the actions mentioned above. There are limits, though, on what sends a claim or appeal straight to an External Review. Your claim or internal appeal will not go straight to External Review if:
- a rule violation was minor and isn’t likely to influence a decision or harm you;
- it was for a good cause or was beyond Aetna’s control; and
- it was part of an ongoing, good faith exchange between you and Aetna.
Independent Health Care Appeals Program (GR-9N-32.051-01 DE) (External Utilization Management Appeal Process)

1. Upon receipt of a Level 2 Utilization Management Appeal adverse benefit determination, if you are dissatisfied with the results, you may pursue a Utilization Management Appeal before an Independent Utilization Review Organization (IURO).

2. You must file the request for an Utilization Management Appeal with Aetna within four (4) months of receipt of the Adverse benefit determination from the Utilization Management Appeal process. Upon receipt of your request for an external review, Aetna shall fax or send an electronic copy of the Petition for External Review form within three (3) business days to the Delaware Department of Insurance and then follow with a hard copy of the request to the Department by mail.

3. Once the request for an external review is received by the Department, the Department will assign an approved IURO to conduct the external review and notify Aetna.

4. Within 5 calendar days of the assignment, the assigned IURO will notify you in writing by certified or registered mail (requesting delivery confirmation by the United States Postal Service), that the Utilization Management Appeal was accepted for external review. This notice will include a provision stating that you, within seven (7) calendar days of this written notice, may submit additional information and supporting document that you would like the IURO to consider when conducting the external review. Upon receipt of any information submitted by you, the assigned IURO shall forward the information to Aetna with in two (2) business days.

5. Within seven (7) business days after Aetna receives notice of the assigned IURO, Aetna shall provide the assigned IURO the documents and any information considered in making the Utilization Management Appeal adverse benefit determination. If Aetna fails to submit this documentation and information or fails to participate within the time specified, the assigned IURO may terminate the external review and make a decision, with the approval of the Department, to reverse the Utilization Management Appeal adverse benefit determination.

6. The external review may be terminated if Aetna decides to reverse its adverse benefit determination and provide coverage or payment for the health care service that is the subject of the Utilization Management Appeal. Immediately upon making this decision, Aetna will notify you, the assigned IURO and the Department in writing of its decision. Upon receipt of this written notice from Aetna, the assigned IURO shall terminate the external review.

7. Within forty-five (45) calendar days after the receipt of the request for external review, the assigned IURO will provide written notice to you (by certified or registered mail requesting delivery confirmation by the United States Postal Service), Aetna and the Department of its decision to uphold or reverse the Aetna adverse benefit determination.

8. The decision of the IURO is binding upon Aetna.

**Expeditied External Utilization Management Appeal Process**

1. You may request an expedited external review with Aetna at the time you receive a final Level 2 adverse benefit determination from Aetna if you suffer from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition.

2. At the time Aetna receives a request for an expedited external review, Aetna shall immediately fax or send an electronic copy of the Petition for External Review form to the Department and mail a hard copy of the form to the Department.

3. If the Department determines that the review meets the criteria for expedited review, the Department will assign an approved IURO to conduct the external review and notify Aetna. Upon receipt of the notification, Aetna will expeditiously provide or transmit all necessary documents and information considered in making the final adverse benefit determination.
4. Within seventy-two (72) after the date of the receipt of the request for an expedited external review, the IURO shall:
   
a) Make a decision to uphold or reverse the final adverse benefit determination; and
b) Immediately notify you, Aetna and the Department of the decision.
c) Within two (2) calendar days of that notification, the IURO shall provide written confirmation of the decision to you, Aetna, and the Department.

5. The decision of the IURO is binding upon Aetna.
In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

**A (GR-9N-34-005-05)**

**Aetna**
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

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

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

**B (GR-9N 34-010 01 DE)**

**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.

Coinsurance
Coinsurance is both the percentage of covered expenses that the plan pays, and the percentage of covered expenses that you pay. The percentage that the plan pays is referred to as “plan coinsurance” and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.

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.

**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.

**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. Network provider information is available through Aetna's online provider directory, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this directory.

**Durable Medical and Surgical Equipment (DME)**

Equipment, and the accessories needed to operate it, that is:

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

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.
**E-visit** *(Applies in the United States as designated in DocFind)*
An **E-visit** is an online internet consultation between a 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.

**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**
Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

- There is not enough 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.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

that states that it is experimental or investigational, or for research purposes.
Generic Prescription Drug
A prescription drug, that is identified by its:
- chemical;
- proprietary; or
- non-proprietary name; and
- is accepted by the U.S. Food and Drug Administration as therapeutically the same; and
- can be replaced with drugs with the same amount of active ingredient; and
- so stated by Medispan or any other publication named by Aetna or consort.

Homebound
This means that you are confined to your place of residence:
- Due to an illness or injury which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered homebound include (but are not limited to) the following:
- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency
An agency that meets all of the following requirements.
- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one physician and one R.N.) which makes policy.
- Has full-time supervision by a physician or an R.N.
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Care Plan
This is a plan that provides for continued care and treatment of an illness or injury. The care and treatment must be:
- Prescribed in writing by the attending physician; and
- An alternative to a hospital or skilled nursing facility stay.

Hospice Care
This is care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice Care Agency
An agency or organization that meets all of the following requirements:
- Has hospice care available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
Provides:
- Skilled nursing services;
- Medical social services; and
- Psychological and dietary counseling.

Provides, or arranges for, other services which include:
- Physician services;
- Physical and occupational therapy;
- Part-time home health aide services which mainly consist of caring for terminally ill people; and
- Inpatient care in a facility when needed for pain control and acute and chronic symptom management.

Has at least the following personnel:
- One physician;
- One R.N.; and
- One licensed or certified social worker employed by the agency.

Establishes policies about how hospice care is provided.

Assesses the patient's medical and social needs.

Develops a hospice care program to meet those needs.

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

Permits all area medical personnel to utilize its services for their patients.

Keeps a medical record on each patient.

Uses volunteers trained in providing services for non-medical needs.

Has a full-time administrator.

**Hospice Care Program**

This is a written plan of hospice care, which:

- Is established by and reviewed from time to time by a physician attending the person, and appropriate personnel of a hospice care agency;
- Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

**Hospice Facility**

A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient hospice care to terminally ill persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians. At least one staff physician must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an R.N.
- Has a full-time administrator.

**Hospital**

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**
A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

**I** *(GR.9N 34-045 02)*

**Illness**
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set 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 give services or supplies to an **IOE** patient in connection with specific transplants, procedures at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants, procedures for which it has signed a contract.

**J** *(GR.9N 34-050 01)*

**Jaw Joint Disorder** *(GR.9N 34-050 01)*
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.
Late Enrollee
This is an employee in an Eligible Class who asked for enrollment under this Plan after the Initial Enrollment Period. Also, this is an eligible dependent for whom the employee did not choose coverage for the Initial Enrollment Period, but for whom coverage is asked for at a later time.

An eligible employee or dependent may not be considered a Late Enrollee at certain times. See the Special Enrollment Periods section of the (Booklet-Certificate).

L.P.N.
A licensed practical or vocational nurse.

Mail Order Pharmacy
An establishment where prescription drugs are legally given out by mail or other carrier.

Maintenance Care
Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give 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, coinsurance, copayments and other eligible out-of-pocket expense apply to the maximum out-of-pocket limit. Once you meet 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 network, out-of-network and outside the United States out-of-pocket expenses.

The following expenses do not apply toward your maximum out-of-pocket limits:
- Charges over the recognized charge;
- Non-covered expenses;
- Any covered expenses which are payable by Aetna at 50%; 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. (Applies in the United States)
Medically Necessary or Medical Necessity
These are 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 give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an illness;
  - an injury;
  - a disease; or
  - its symptoms.

The provision of the service, supply or prescription drug must be:

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 mostly for the convenience of the patient, physician, other health care or dental provider; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same 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. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with physician or dental specialty society recommendations. They must be consistent with 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.

Any one of the following conditions is a mental disorder under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizoaffective disorder.
- Schizophrenia.

Also included is any other mental condition which requires Medically Necessary treatment.

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.
Negotiated Charge *(Applies in the United States)*

As to health expense coverage, other than Prescription Drug Expense Coverage:

The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:
The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna**, an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Advanced Reproductive Technology (ART) Specialist

A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology (ART)** services.

Network Provider

A health care provider or **pharmacy** who has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna**’s consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**

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.

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.

Other Health Care
A health care service or supply that is neither network service(s) or supply(ies) nor out-of-network service(s) and supply(ies). Other health care can include care given by a provider who does not fall into any of the categories in your provider directory (or in DocFind at Aetna’s website).
Out-of-Network Service(s) and Supply(ies) (GR-9N:34-075-01 DE)

Health care service or supply that is:

- Furnished by an **out-of-network provider**; or
- Not **other health care**.

**Out-of-Network Provider**

A health care provider or **pharmacy** who has not contracted with Aetna, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

**Partial Confinement Treatment**

A plan of medical, psychiatric, nursing, counseling, and/or therapeutic services to treat **mental disorders** and **substance abuse**. 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.

**Pharmacy**

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

**Physician**

A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

**Precertification or Precertify**

A process where Aetna is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.
Preferred Drug Guide
A listing of prescription drugs established by Aetna or an affiliate, which includes both brand name prescription drugs and generic prescription drugs. This list is subject to periodic review and modification by Aetna or an affiliate. A copy of the preferred drug guide will be available upon your request or may be accessed on the Aetna website at www.Aetna.com/formulary.

Preferred Drug Guide Exclusions List
A list of prescription drugs in the preferred drug guide that are identified as excluded under the plan. This list is subject to periodic review and modification by Aetna.

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

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

Prescription Drug
A drug, biological, or compounded prescription which, by State and Federal Law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription."
This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

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.
Recognized Charge

The amount of an out-of-network provider's charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider's full charge.

Your plan's recognized charge applies to all out-of-network covered expenses except out of network emergency services. It applies even to charges from an out-of-network provider in a hospital that is a network provider. It also applies when your PCP or other network provider refers you to an out-of-network provider. Except for Aetna facility fee schedule, the recognized charge is determined based on the Geographic area where you receive the service or supply.

A service or supply provided by a provider is treated as covered expenses under the other health care coverage category when:

- You get services or supplies from an out-of-network provider. This includes when you get care from out-of-network providers during your stay in a network hospital.
- You could not reasonably get the services and supplies needed from a network provider.

The other health care coverage does not apply to services or supplies you receive in an out-of-network emergency room.

When the other health care coverage applies, you will pay the other health care cost share.

Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and:

- For professional services and for other services or supplies not mentioned below: 105% of the Medicare allowable rate
- For services of hospitals and other facilities: 140% of the Medicare allowable rate
- For prescription drugs: 110% of the Average wholesale price (AWP)

For emergency services, the recognized charge is the negotiated charge for providers with whom we have a direct contract but are not network providers.

We have the right to apply Aetna reimbursement policies. Those policies may further reduce the recognized charge. These policies take into account factors such as:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the provider

Aetna reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of physicians and dentists practicing in the relevant clinical areas
We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used
**Aetna facility fee schedule**, Average wholesale price (AWP), Geographic area, and Medicare allowable rates are defined as follows:

**Aetna facility fee schedule**
The schedule of rates we developed using our data or experience for out-of-network facility services and supplies. We adjust the schedule from time to time at our discretion.

**Average wholesale price (AWP)**
Is the current average wholesale price of a prescription drug listed in the Medi-span weekly price updates (or any other similar publication chosen by Aetna).

**Geographic area**
The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic area such as an entire state.

**Medicare allowable rates**
Except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we will determine the rate as follows:
- Use the same method CMS uses to set Medicare rates.
- Look at what other providers charge.
- Look at how much work it takes to perform a service.
- Look at other things as needed to decide what rate is reasonable for a particular service or supply.

**Additional information:**
Get the most value out of your benefits. Use the “Estimate the Cost of Care” tool on Aetna Navigator® to help decide whether to get care in network or out-of-network. Aetna’s secure member website at www.aetnainternational.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools.

**Rehabilitation Facility**
A facility, or a distinct part of a facility which provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

**Rehabilitative Services**
The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by illness or injury.

**Residential Treatment Facility (Mental Disorders)**
This is an institution that meets all of the following requirements:

- 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.

**Residential Treatment Facility (Substance Abuse)**

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

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

**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.
Self-injectable Drug(s)
Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

Semi-Private Room Rate
The room and board charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area (Applies in the United States)
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.

Step Therapy
A form of precertification under which certain prescription drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by Aetna or an affiliate. An updated copy of the list of drugs subject to step therapy shall be available upon request by you or may be accessed on the Aetna website at www.Aetna.com/formulary.

Substance Abuse
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery Center
A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital; and
  - Dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions.

Must have all of the following:

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

**Telemedicine**
A telephone or internet based consult with a **provider** that has contracted with **Aetna** to offer these services.

**Terminally Ill (Hospice Care)**
**Terminally ill** means a medical prognosis of 6 months or less to live.

**Therapeutic Drug Class**
A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

**Urgent Admission**
A **hospital** admission by a **physician** due to:
- The onset of or change in an **illness**; or
- The diagnosis of an **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 Facility**
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

**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.
  - Charges for its services and supplies.
  - 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.

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**Walk-in Clinic**

*Walk-in Clinics* are 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.*
Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law.

In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna international.com.
Additional Information Provided by
Adobe Systems Incorporated

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

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

**Name of Plan:**
Refer to your Plan Administrator for this information

**Employer Identification Number:**
Refer to your Plan Administrator for this information

**Plan Number:**
Refer to your Plan Administrator for this information

**Type of Plan:**
Welfare

**Type of Administration:**
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

**Plan Administrator:**
Adobe Systems Incorporated
Attention: Susan Burke - Mgr, Vendor Partner Office
345 Park Avenue W07-431
San Jose, CA 95110
Telephone Number: (408) 536-4433

**Agent For Service of Legal Process:**
Adobe Systems Incorporated
Attention: Susan Burke - Mgr, Vendor Partner Office
345 Park Avenue W07-431
San Jose, CA 95110
Telephone Number: (408) 536-4433

Service of legal process may also be made upon the Plan Administrator

**End of Plan Year:**
December 31

**Source of Contributions:**
Employer and Employee
Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

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

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

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

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

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

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

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

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

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

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

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

**Assistance with Your Questions**

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

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

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Statement of Rights under the Newborns' and Mothers' Health Protection Act
Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

Notice Regarding Women's Health and Cancer Rights Act
Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

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

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

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

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

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

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

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

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

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

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

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

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

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

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.
GLOBAL EMERGENCY ASSISTANCE PROGRAM
One call, one standard for managing emergencies while traveling abroad

Aetna International® (AI) provides international travelers with access to global emergency assistance resources that are available through a single call 24 hours a day, 7 days a week. AI provides access to the following emergency assistance services:

- **Emergency or Urgent Medical Evacuation**: Evacuation services may be necessary if a member or eligible dependent develops an emergency or urgent medical situation requiring immediate attention and adequate medical facilities are not locally available. The plan will cover payment of medically supervised evacuations to the closest facility capable of providing appropriate care.

- **Medical Repatriation Coordination**: Following an evacuation, the plan will cover payment for a one way economy fare to either the member’s point of origin or to the permanent residence, or, if appropriate, to a facility as defined by the plan if it is medically advisable following patient stabilization. This may include any medically supervised transportation or medical treatment administered en route.

- **Return of Mortal Remains**: The benefit covers obtaining the necessary clearances for cremation or the return of member’s mortal remains in the event that the member dies while abroad, including coordination and plan payment of expenses associated with cremation or preparation and return of remains.

- **Return of Dependent Children**: A plan-paid one-way economy air fare to the child’s permanent residence is covered when left unattended as a result of a member’s accident or illness. Coverage for a qualified attendant will also be provided, if required.

- **Companion Travel Coordination**: Following an evacuation, if a member is alone and hospitalized for more than seven (7) days, a plan-paid economy round-trip air fare to the place of hospitalization is covered for one person chosen by the member.

Convalescent Lodging Coverage: "Convalescent hotel expenses" are covered after evacuation and release from the hospital for illnesses or injury until member is fit to fly to return to point of origin. Also coverage is provided for accommodations for a family member to accompany a patient under the age of 18 after evacuation for hospitalization and convalescence only.

Medical necessity information (note from physician stating time period for convalescence) must be submitted with claims to support the length of time covered for convalescence. Receipts for any/all of the covered travel and lodging expenses must be received within six months of the date of service in order to be considered for reimbursement.

Exclusions:

- Meals
- Personal care items (e.g., shampoo, deodorant, etc.)
- Telephone calls
- Ground transportation

Medical Assistance Services

- **Pre-Trip Planning**: Assistance with up to date information either by email, fax or over the phone regarding required vaccinations, health risks, travel restrictions and weather conditions for worldwide destinations.

- **Medical, Dental and Pharmacy Referrals**: Members may request referrals to the most appropriate, nearby medical care resources, including preferred access to Aetna’s network of medical providers.
• **Dispatch of Medicine, Vaccines:** Assistance is available to obtain prescription medicine, vaccines, when not locally available and when legally permissible, upon the written authorization of member’s Primary Physician.

• **Dispatch of Physician/Nurse:** Dispatch to the member’s location a physician or other healthcare professional to assist in determining the medical condition and suitability to travel of a Member who has been hospitalized.

**NOTE:** All evacuations, returns to residence after stabilization, and/or repatriations of mortal remains are coordinated by and subject to the prior approval of Aetna International.

**How To Take Advantage of Your Assistance Service Benefits:**

Call the Global Emergency Assistance number on your ID card at 1-877-242-5580 if you or your eligible dependents:

• have a medical concern or question;
• are hospitalized or are about to be hospitalized;
• are involved in an accident requiring medical treatment;
• are having difficulty locating medical care;
• require translation services; or
• have other serious difficulties while located abroad.

If the condition is an emergency, you or your eligible dependents should go immediately to the nearest physician or hospital without delay and then contact AI. While Aetna International will do everything reasonably possible to direct you or your eligible dependents to the most appropriate care available once a call has been initiated, they are not responsible for the availability, quantity, quality or result of any medical treatment you may receive, or your failure to obtain medical treatment.

Global Emergency Assistance is available through AI 24 hours a day, 7 days a week, 365 days a year using the same telephone number from anywhere in the world.

You or your eligible dependents must always provide your Policy name and number and your name and Identification Number as the individual through which this group coverage has been made available. If you are not the individual seeking assistance, your eligible dependents must also provide their name.

The nature of the illness, injury, medical problem or emergency in question and the type of help that is needed should be explained to our intake coordinators at AI.

**Expenses Not Covered Under the Global Emergency Assistance Program:**

The Global Emergency Assistance Program shall not be responsible for the cost of services or expenses arising from:

• Your or your eligible dependents’ suicide, attempted suicide, or willful self-inflicted injury, sexually transmittable diseases, or the abuse of drugs or alcoholic drink;
• Your or your eligible dependents’ taking part in military or police service operations;
• The commission of or attempting to commit an unlawful act; or
• Aviation, except where you or your eligible dependents fly as a passenger in an aircraft properly licensed to carry passengers (except the Military Aircraft Command of the United States or similar air transport service of other countries.)
• You or your eligible dependents:
  – traveling against the advice of a physician;
  – traveling for the purposes of obtaining medical treatment; or
• Non-emergency expenses for routine or minor medical problems, tests, and exams where there is no clear or significant risk of death or imminent serious injury or harm to you or your eligible dependents.
• A condition which would allow for treatment at a future date convenient to you or your eligible dependents and which does not require emergency evacuation.
• Incidental expenses, including but not limited to, accommodations and meals incurred in connection with an emergency evacuation.
- Local emergency transportation expenses, including ground ambulance fees for you and your eligible dependents' initial transportation to local hospitals.
- Mountaineering or rock climbing necessitating the use of guide ropes, potholing, ballooning, motor racing, speed contests, skydiving, hang gliding, parachuting, spelunking, heli-skiing, extreme skiing or bungee cord jumping, deep sea diving utilizing hard helmet with air hose attachments, racing of any kind other than on foot and all professional sports.

Failure to contact AI in a timely manner may invalidate your eligibility for payment of transportation expenses. In addition, if the evacuation method or destination goes outside the boundaries of this program description, it may invalidate payment of subsequent transportation expenses.

Any bills incurred by you or your eligible dependents relating to assistance services must be submitted to AI in order to obtain payment consideration.

Note: As used throughout this section, the term "emergency" shall be defined to mean a situation when, in the professional opinion of your physician, a clear and significant risk of death or imminent serious injury or harm to you or your eligible dependents exists.
On-line Global Health and Travel Information from HTH Worldwide

Through an arrangement with HTH Worldwide (known as “HTH”), Aetna International ® (AI) can now offer you and your eligible dependents access to useful information specifically designed to help global employees and their families research and pursue quality health care virtually anywhere in the world. HTH is a leading provider of web-based health and travel information and services that are specifically tailored to help address the global needs of individuals living, working and traveling outside their home country.

By visiting the AI Member website http://www.aetnainternational.com you and your eligible dependents can access a suite of self-service, web based tools that may help you to be more self-reliant and better prepared for health related issues you may encounter during your international assignment.

Through AI’s online Member Service Center, you will have access to the important resources described in the following section(s).

What Types of Resources Are Available Through HTH?

Provider Community

International Provider Community – A community of over 2,500 English-speaking, pre-identified physicians, dentists, psychologists and other allied health professionals who are located in over 120 countries and who represent 24 medical specialties recognized by the American Board of Medical Specialties.

Providers are selected based on their professional qualifications, clinical experience, hospital affiliations, language skills, continuing medical education, peer recommendations, and positive experience with expatriate patients. Hand-selected providers must also have one of the following: verified current American Board of Medical Specialties certification; verified current Royal Medical or Surgical College membership (from the United Kingdom, Ireland, Canada, Australia, or New Zealand); and/or recommendation by HTH Regional Physician Advisors (RPA), HTH Medical Staff, and/or HTH Recruitment Partner.

In addition to professional qualification information, provider profiles also include ancillary details, which are verified 6 times annually, such as:
- Practice address and contact details
- Email address
- Language(s)
- Special Services (house calls, ambulance, onsite lab)
- Hospital Affiliations

Interactive/Online Tools

Provider search tool – This utility allows you to conduct a personalized on-line search of HTH’s International Provider Community to identify and research physicians and other providers that meet your geographic and medical specialty criteria. A convenient link is also provided to Aetna’s DocFind search engine, which provides information about the broad network of Aetna providers across the United States.

Health and Security Information

CityHealth Profiles™ - Information on the healthcare services in the world’s most frequent destinations for international assignees and business travelers. Valuable information that includes, but is not limited to the following, is presented at both a city and country level for more than 200 destinations outside of the United States:
- Notable hospital profiles – key facilities are profiled based upon their location, clinical services, track record of quality service, medical staff, equipment, accessibility for international patients and recommendations from HTH’s network of 90+ Regional Physician Advisors.
- Health risks & vaccination recommendations
- Pharmacy Information – reliability, typical hours, etc
Health System Profiles provides a unique and succinct evaluation of the health system of many commonly visited countries. Such profiles address critical points of interest, including health insurance and financing issues, hospital and physician access, and quality of care.

Health News and Security Information – Critical health and security news from around the world, including disease outbreak information, travel advisories and public announcements from the U.S. State Department. Available security report topics include:
- Country & city overviews
- Cultural tips
- Security situation(s), including hijacking & kidnapping risks
- Crime, including terrorism & street crime(s)
- Political Stability, including demonstration(s)
- Police and Fire Safety
- Airport, Airlines & Hotels and Ground Transportation Information
- Communications

Translation Guides – Annually updated, interactive tools that allow you to:
- Drug Translation Guide – select the brand names of prescriptions and over-the-counter medications you may use in your home country to determine their local generic equivalent name and whether they are available in your host country. The Drug Translation Guide, which supports country-specific brand/generic drug name(s) and preparation(s) in 21-plus frequently visited countries, can also be used to identify the name(s) of the local manufacturer(s)/distributor(s) of such medications, as well as the locally used generic or brand name(s) and formulations for the product.
- Medical Terms and Phrases – get translations of commonly used medical terms and phrases from your native language into the language of the country where you are traveling or living. The Medical Terms and Phrases tool contains translations for more than 600 commonly used technical and layperson medical terms in, including but not limited to, English, French, German, Spanish, Portuguese, and Italian. Additionally, Chinese, Japanese, and Russian are available in PDF format.

The Medical Terms translation tool provides assistance in translating names of diseases and medical conditions, body parts, medical equipment, diagnostic tests and procedures.

The Medical Phrases translation tool provides assistance in helping patients to express their symptoms, needs and questions to hospital staff or pharmacy personnel who may not possess the same degree of English fluency as the physicians.

News and Features
- Healthy Travel/Life Abroad Feature Articles – Feature length articles written for expatriates and business travelers by HTH Worldwide staff and medical advisors. Sample topics include managing jet lag, avoiding traveler’s diarrhea, and traveling safely with chronic illnesses such as diabetes. The Travel Health Center articles fit into four general categories: “Expatriate Travel Health”, “Business Travel Health”, “General Travel Health”, and “Special Needs Travel Health.”
Customer Support Services 24 hours a day
If you have any questions about the AI Member website or if you require assistance using any of the tools, please call the AI Member Service Center at the number shown on your Identification Card, 24 hours a day, 7 days a week.

Toll free calling is available in much of the world. Please consult the AT&T Wallet Card included in your Welcome Kit or go to https://www.business.att.com/bt/dial_guide.jsp to find the access numbers for your country.

Note: Neither HTH Worldwide nor Aetna International is a healthcare provider and neither shall be responsible for the availability, quantity, quality or result of medical treatment you or your eligible dependents may receive or for your failure to obtain medical treatment.
International Employee Assistance Program

Aetna International ® (AI) is providing you and your eligible dependents with an International Employee Assistance Program (IEAP). This program offers a full spectrum of behavioral health and work/life services designed to promote overall wellness and help make life more manageable.

There are many aspects of your life. Sometimes trying to juggle them all—work, family, parents, and life—can be challenging. It can be frustrating when you don’t know where to go for help, support, or just a listening ear. The Aetna IEAP has services that can help. The Aetna IEAP is designed for anyone who could use a little help in managing demanding everyday situations. You can think of it as your “life management resource.”

Program Overview
IEAP provides you and your eligible dependents with 24-hour toll-free* access to confidential behavioral health services and resources. Your IEAP is available at no cost to you. IEAP services include but are not limited to:

- Up to 5 counseling sessions per issue per year;
- Web-based health and wellness content and self-assessment tools;
- Crisis Management; and
- Consultation for supervisors managing issues in the workplace.

Focus of IEAP for the International Employee:
IEAP addresses the issues you and your eligible dependents may face when located internationally such as:

- Difficulties with cultural adjustment and feelings of isolation;
- Marital and family relationship stress;
- Child care and behavioral concerns;
- Social adaptation needs;
- Alcohol/Substance Abuse;
- Balancing work and home life; and
- Depression.

Multi-lingual Requirements
IEAP staff has multilingual capability to assist multilingual callers. When necessary, access to language translation services is also available.

How You and Your Eligible Dependents Can Access the International Employee Assistance Program and Related Information:

You will receive an IEAP insert in your member kit. The insert contains an overview of the IEAP services, the toll-free* telephone number and web site address.

*Toll-free calling is available in much of the world. Collect calls are accepted if you or your eligible dependents have no access to toll-free calling. See the IEAP insert or your Employer for details.

NOTE: Aetna does not render health care services and/or treatments and, therefore, cannot guarantee any results or outcomes. All participating providers are independent contractors and are neither agents nor employees of Aetna. The availability of any provider cannot be guaranteed and the provider network composition is subject to change.
INFORMED HEALTH® Line

A nurse-facilitated health information service designed to help you become a better health care consumer

Arrangements have been made with Informed Health, Inc., an Aetna Life Insurance Company subsidiary company that offers an information service to assist people like you in becoming better consumers of health care. The service, Informed Health Line (IHL), provides you and your eligible dependents with toll-free*, 24-hour access to credible health information. You can either:

(Alternative 1:) Speak to an experienced, U.S.-based, registered nurses who can:

- Answer questions about health concerns
- Provide current, easy to understand information on a wide-range of health issues such as:
  - common prevention strategies
  - chronic conditions; and
  - complex medical situations
- Discuss options for seeking medical attention
- Help you and your eligible dependents prepare for appointments with your providers

To assist multi-lingual callers, registered nurses have access to AT&T’s language translation service.

(NOTE: Informed Health nurses cannot diagnose, prescribe, or give medical advice.)

(Alternative 2:) Access an audio health library from any touch-tone phone, 24 hours-a-day. The audio health library, which is available in either English or Spanish, offers you and your eligible dependents increased flexibility by allowing you to choose how you access the health information you need. You can decide to speak to a nurse right away or go directly to the audio health library which contains information on thousands of health topics including common conditions and diseases, gender and age-specific health issues, mental health/ substance abuse, weight loss and much more. Information for the particular conditions specified will be made available through the Audio Health Library by entering a four-digit code that corresponds to the condition.

Advantages of IHL:

Informed Health Line offers useful information to educate you and your eligible dependents about a variety of health topics; increase your awareness and understanding of important health issues; and help you to more effectively communicate with your providers.

For you and your eligible dependents: The IHL service offers 24-hour access to health information provided by qualified U.S.-based professionals, as well as supplemental written materials. These tools may help empower you to actively participate in your care and may help improve the effectiveness and efficiency of that care. For example, information provided by Informed Health Line nurses may help you identify problems to your physicians that might otherwise be ignored, thus leading to early treatment of potentially serious and costly health conditions.

How You Can Take Advantage of Informed Health Line Services:

You may receive:

- a convenient AT&T wallet card that provides the toll-free* telephone number through which health information services can be accessed;
- a welcome flyer that provides an overview of the services available through Informed Health;
- information from on-line medical databases and journals (mailed to you upon request); and
- access to round-the-clock, toll-free*, confidential health care information Both the Audio Health Library and the Service’s U.S.-based registered nurses are available 24 hours a day, 7 days a week.
You or your eligible dependents can call the toll-free* number that has been provided.

NOTE: Neither Aetna International ® nor Informed Health is a healthcare provider and neither shall be responsible for the availability, quantity, quality, or result of any medical treatment a member may receive, or for a member’s failure to pursue or obtain medical treatment.

* Toll-free calling is available in much of the world. Refer to your Plan’s AT&T Wallet Card for available locations.
Schedule of Benefits

Employer: Adobe Systems Incorporated

Control Number: 447926

Issue Date: March 1, 2016
Effective Date: January 1, 2016
Schedule: 1A
Cert Base: 1

For: PPO Medical and Pharmacy

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

PPO Medical Plan

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK (In the U.S.)</th>
<th>OUT-OF-NETWORK (In the U.S.)</th>
<th>OUTSIDE THE U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible*</td>
<td>$100</td>
<td>$300</td>
<td>$100</td>
</tr>
<tr>
<td>Family Deductible*</td>
<td>$300</td>
<td>$900</td>
<td>$300</td>
</tr>
<tr>
<td>Per Admission Deductible*</td>
<td>Not applicable</td>
<td>$250 per admission</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

*Unless otherwise indicated, any applicable deductible must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan deductible and copayments.

Plan Maximum Out of Pocket Limit excludes precertification penalties.

Individual Maximum Out of Pocket Limit:

- For network expenses: $500.
- For out-of-network expenses: $1,500.
- For outside the United States expenses: $500.

Family Maximum Out of Pocket Limit:

- For network expenses: $1,000.
- For out-of-network expenses: $3,000.
- For outside the United States expenses: $1,000.
## PLAN FEATURES

<table>
<thead>
<tr>
<th></th>
<th>NETWORK (In the U.S.)</th>
<th>OUT-OF-NETWORK (In the U.S.)</th>
<th>OUTSIDE THE U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum Benefit Per Person</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

*Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles and the remaining coinsurance. 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.*

*Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network, out-of-network and outside the United States, unless specifically stated otherwise.*

Other Health Care (Out-of-Area): When care is provided in the U.S. in a geographic area in which Aetna has not contracted with a provider, charges are payable at 80% after any applicable Deductible (does not apply to those expenses paid at a reduced payment percentage). The benefit levels associated with the following In-Network provisions would apply: Deductible, Family Deductible, Inpatient Hospital Deductible, Out-of-pocket maximum(s).

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK (In the U.S.)</th>
<th>OUT-OF-NETWORK (In the U.S.)</th>
<th>OUTSIDE THE U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Physical Exams</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults and Children.</td>
<td>100% per exam</td>
<td>70% per exam after</td>
<td>80% per exam</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year</td>
<td>Calendar Year <strong>deductible</strong></td>
<td>Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes coverage for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>immunizations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Exams per 24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>consecutive month period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults, age 18 to 65</td>
<td>1 exam</td>
<td>1 exam</td>
<td>1 exam</td>
</tr>
<tr>
<td>Maximum Exams per 12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>consecutive month period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults, age 65 and over</td>
<td>1 exam</td>
<td>1 exam</td>
<td>1 exam</td>
</tr>
</tbody>
</table>

GR-9N 2
<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK (In the U.S.)</th>
<th>OUT-OF-NETWORK (In the U.S)</th>
<th>OUTSIDE THE U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness Benefits (cont’d)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Well Child Exams</strong></td>
<td>100% per exam</td>
<td>70% per exam after</td>
<td>80% per exam after</td>
</tr>
<tr>
<td>Includes coverage for</td>
<td>No Calendar Year</td>
<td>Calendar Year <strong>deductible</strong></td>
<td>Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td>immunizations and Child</td>
<td>deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Testing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Exams</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>first 12 months of life</td>
<td>7 exams</td>
<td>7 exams</td>
<td>7 exams</td>
</tr>
<tr>
<td>13th-24th months of life</td>
<td>3 exams</td>
<td>3 exams</td>
<td>3 exams</td>
</tr>
<tr>
<td>25th-36th months of life</td>
<td>3 exams</td>
<td>3 exams</td>
<td>3 exams</td>
</tr>
<tr>
<td>Maximum Exams per 12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>consecutive month period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From age 3 to age 18</td>
<td>1 exam</td>
<td>1 exam</td>
<td>1 exam</td>
</tr>
<tr>
<td><strong>Family Planning Services (GR-9N-S-10-015-01 DE)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family Planning Services</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Routine Gynecological Exam</strong></td>
<td>100% per exam</td>
<td>70% per exam after</td>
<td>80% per exam after</td>
</tr>
<tr>
<td>No Calendar Year <strong>deductible</strong></td>
<td></td>
<td>Calendar Year <strong>deductible</strong></td>
<td>Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td>Maximum Exams per Calendar Year</td>
<td>1 exam</td>
<td>1 exam</td>
<td>1 exam</td>
</tr>
<tr>
<td><strong>Hearing Exam</strong></td>
<td>100% per exam</td>
<td>70% per exam after</td>
<td>80% per exam after</td>
</tr>
<tr>
<td>No Calendar Year <strong>deductible</strong></td>
<td></td>
<td>Calendar Year <strong>deductible</strong></td>
<td>Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td>Maximum Exams per 24</td>
<td>1 exam</td>
<td>1 exam</td>
<td>1 exam</td>
</tr>
<tr>
<td>consecutive month period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK (In the U.S.)</td>
<td>OUT-OF-NETWORK (In the U.S)</td>
<td>OUTSIDE THE U.S.</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------</td>
<td>-----------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Wellness Benefits (cont’d)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Aids for Children Under Age 24</strong> (GR 9N S-10-080-02 DE)</td>
<td>90% per item after Calendar Year deductible</td>
<td>70% per item after Calendar Year deductible</td>
<td>80% per item after Calendar Year deductible</td>
</tr>
<tr>
<td>Maximum Benefit (GR 9N S-10-080-02 DE)</td>
<td>$1,000 per individual hearing aid, per ear, every three years.</td>
<td>$1,000 per individual hearing aid, per ear, every three years.</td>
<td>$1,000 per individual hearing aid, per ear, every three years.</td>
</tr>
</tbody>
</table>

| **Routine Cancer Screenings** (GR 9N S-10-015-01 DE) |                       |                             |                  |
| **Routine Mammography** | 100% per test | 70% per test after Calendar Year deductible | 80% per test after Calendar Year deductible |
|                           | No Calendar Year deductible applies. |                       |                  |
| Maximum Tests per Calendar Year | Unlimited tests | Unlimited tests | Unlimited tests |

| **Prostate Specific Antigen Test** | 100% per test | 70% per test after Calendar Year deductible | 80% per test after Calendar Year deductible |
| For covered males age 40 and over | No Calendar Year deductible applies. |                       |                  |
| Maximum Tests per Calendar Year | 1 test | 1 test | 1 test |

| **Routine Digital Rectal Exam** | 100% per exam | 70% per exam after Calendar Year deductible | 80% per exam after Calendar Year deductible |
| For covered males age 40 and over | No Calendar Year deductible applies. |                       |                  |
| Maximum Exams per Calendar Year | 1 exam | 1 exam | 1 exam |

| **Routine Pap Smears** | 100% per test | 70% per test after Calendar Year deductible | 80% per test after Calendar Year deductible |
| No Calendar Year deductible applies. |                       |                  |
| Maximum Tests per Calendar Year | 1 test | 1 test | 1 test |
### PLAN FEATURES

<table>
<thead>
<tr>
<th>Routine Cancer Screenings (GR-9N-S.10-015-01 DE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fecal Occult Blood Test</strong></td>
</tr>
<tr>
<td><strong>(In the U.S.)</strong> Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>OUT-OF-NETWORK (In the U.S)</strong> Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>OUTSIDE THE U.S.</strong> Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Maximum Tests per 12 consecutive month period</td>
</tr>
</tbody>
</table>

| **Sigmoidoscopy** |
| **(In the U.S.)** Payable in accordance with the type of expense incurred and the place where service is provided. |
| **OUT-OF-NETWORK (In the U.S)** Payable in accordance with the type of expense incurred and the place where service is provided. |
| **OUTSIDE THE U.S.** Payable in accordance with the type of expense incurred and the place where service is provided. |
| Maximum Tests per 5 consecutive year period | 1 test | 1 test | 1 test |

| **Double Contrast Barium Enema (DCBE)** |
| **(In the U.S.)** Payable in accordance with the type of expense incurred and the place where service is provided. |
| **OUT-OF-NETWORK (In the U.S)** Payable in accordance with the type of expense incurred and the place where service is provided. |
| **OUTSIDE THE U.S.** Payable in accordance with the type of expense incurred and the place where service is provided. |
| Maximum Tests per 5 consecutive year period | 1 test | 1 test | 1 test |

| **Colonoscopy** |
| **(In the U.S.)** Payable in accordance with the type of expense incurred and the place where service is provided. |
| **OUT-OF-NETWORK (In the U.S)** Payable in accordance with the type of expense incurred and the place where service is provided. |
| **OUTSIDE THE U.S.** Payable in accordance with the type of expense incurred and the place where service is provided. |
| Maximum Tests per 10 consecutive year period | 1 test | 1 test | 1 test |

### Vision Care (GR-9N-S.10-020-01)

<p>| <strong>Eye Examinations</strong> (including refraction) 100% per exam No Calendar Year deductible applies. |
| <strong>(In the U.S.)</strong> Payable in accordance with the type of expense incurred and the place where service is provided. |
| <strong>OUT-OF-NETWORK (In the U.S)</strong> Payable in accordance with the type of expense incurred and the place where service is provided. |
| <strong>OUTSIDE THE U.S.</strong> Payable in accordance with the type of expense incurred and the place where service is provided. |
| Maximum Benefit per 24 consecutive month period | 1 exam | 1 exam | 1 exam |</p>
<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK (In the U.S.)</th>
<th>OUT-OF-NETWORK (In the U.S.)</th>
<th>OUTSIDE THE U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Services (GR-9N:S-10-25-02)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visits (non-surgical)</td>
<td>$10 per visit copay then the plan pays 100%</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Office Visits</td>
<td>$10 per visit copay then the plan pays 100%</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician Services (cont’d) (GR-9N:S-10-25-02)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visits-Surgery</td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>Walk-In Clinic Non-Emergency Visit (GR-9N:S-10-25-03 DE)</td>
<td>$10 per visit copay then the plan pays 100%</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services for Inpatient Facility and Hospital Visits</td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>Administration of Anesthesia</td>
<td>90% per procedure after Calendar Year deductible</td>
<td>70% per procedure after Calendar Year deductible</td>
<td>80% per procedure after Calendar Year deductible</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>Immunizations (when not part of the physical exam)</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Prenatal Visits</td>
<td>100% per visit</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK (In the U.S.)</td>
<td>OUT-OF-NETWORK (In the U.S.)</td>
<td>OUTSIDE THE U.S.</td>
</tr>
<tr>
<td>-------------------------------</td>
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<td>-------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Emergency Medical Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Facility</td>
<td>90% per visit</td>
<td>90% per visit</td>
<td>90% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Emergency Care in a Hospital Emergency Room</strong></td>
<td>50% per visit after Calendar Year deductible</td>
<td>50% per visit after Calendar Year deductible</td>
<td>90% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Urgent Care Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Medical Care (at a non-hospital free standing facility)</td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>Urgent Medical Care (from other than a non-hospital free standing facility)</td>
<td>Refer to Emergency Medical Services and Physician Services above.</td>
<td>Refer to Emergency Medical Services and Physician Services above.</td>
<td>Refer to Emergency Medical Services and Physician Services above.</td>
</tr>
<tr>
<td>Non-Urgent Use of Urgent Care Provider (at an Emergency Room or a non-hospital free standing facility)</td>
<td>50% per visit after Calendar Year deductible</td>
<td>50% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic and Preoperative Testing (GR.9N.5-10.035-01)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex Imaging</td>
<td>90% per test after Calendar Year deductible</td>
<td>70% per test after Calendar Year deductible</td>
<td>80% per test after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Diagnostic Laboratory Testing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Laboratory Testing</td>
<td>90% per procedure after Calendar Year deductible</td>
<td>70% per procedure after Calendar Year deductible</td>
<td>80% per procedure after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Diagnostic X-Rays</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic X-Rays</td>
<td>90% per procedure after Calendar Year deductible</td>
<td>70% per procedure after Calendar Year deductible</td>
<td>80% per procedure after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Outpatient Surgery (GR.9N.5-10.040-01)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>90% per visit/surgical procedure after Calendar Year deductible</td>
<td>70% per visit/surgical procedure after Calendar Year deductible</td>
<td>80% per visit/surgical procedure after Calendar Year deductible</td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK (In the U.S.)</td>
<td>OUT-OF-NETWORK (In the U.S.)</td>
<td>OUTSIDE THE U.S.</td>
</tr>
<tr>
<td>---------------</td>
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<td>-----------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Inpatient Facility Expenses</strong> (GR-9N 5.10.45.01)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Birthing Center</em></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Hospital Facility Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and Board (including maternity)</td>
<td>90% per admission after Calendar Year deductible</td>
<td>$250 per admission deductible after Calendar Year deductible, then the plan pays 70%</td>
<td>90% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td>Other than Room and Board</td>
<td>90% per admission after Calendar Year deductible</td>
<td>70% per admission after Calendar Year deductible</td>
<td>80% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Skilled Nursing Inpatient Facility</strong></td>
<td>90% per admission after Calendar Year deductible</td>
<td>$250 per admission deductible after Calendar Year deductible, then the plan pays 70%</td>
<td>90% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Maximum Days per Calendar Year</strong></td>
<td>120 days</td>
<td>120 days</td>
<td>120 days</td>
</tr>
<tr>
<td><strong>Specialty Benefits</strong> (GR-9N-10.50.01)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Home Health Care (Outpatient)</em></td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Maximum Visits per Calendar Year</strong></td>
<td>120 visits</td>
<td>120 visits</td>
<td>120 visits</td>
</tr>
<tr>
<td><strong>Specialty Benefits (cont’d) (GR-9N-10.50.01)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Skilled Nursing Care (Outpatient)</em></td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
</tbody>
</table>
# Plan Features

## Hospice Benefits

<table>
<thead>
<tr>
<th>Hospice Care – Facility Expenses (Room &amp; Board)</th>
<th>Hospice Care – Other Expenses during a stay</th>
<th>Out-of-Network (In the U.S.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% per admission after Calendar Year deductible</td>
<td>70% per admission after Calendar Year deductible</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
</tbody>
</table>

### Maximum Benefit per lifetime

- **In the U.S.**
  - Hospice Benefits: 30 days
  - Infertility Treatment: 30 days
  - Inpatient Treatment of Mental Disorders: 30 days

## Infertility Treatment (GR.9N.S.10.033.01)

### Basic Infertility Expenses

Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.

<table>
<thead>
<tr>
<th>Room and Board</th>
<th>90% per admission after Calendar Year deductible</th>
<th>70% per admission after Calendar Year deductible</th>
<th>80% per admission after Calendar Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other than Room and Board</td>
<td>90% per admission after Calendar Year deductible</td>
<td>70% per admission after Calendar Year deductible</td>
<td>80% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td>Physician Services</td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
</tbody>
</table>

## Inpatient Treatment of Mental Disorders (GR.9N.S.10.062.01 DE)

### MENTAL DISORDERS

#### Hospital Facility Expenses

<table>
<thead>
<tr>
<th>Room and Board</th>
<th>90% per admission after Calendar Year deductible</th>
<th>$250 per admission deductible after Calendar Year deductible, then the plan pays 70%</th>
<th>90% per admission after Calendar Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other than Room and Board</td>
<td>90% per admission after Calendar Year deductible</td>
<td>70% per admission after Calendar Year deductible</td>
<td>80% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td>Physician Services</td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK (In the U.S.)</td>
<td>OUT-OF-NETWORK (In the U.S.)</td>
<td>OUTSIDE THE U.S.</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------</td>
<td>-----------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Inpatient Treatment of Mental Disorders (cont’d)</strong>&lt;br&gt;(GR-9N-5-10-062-01 DE)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Residential Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility Expenses</td>
<td>90% per admission after Calendar Year deductible</td>
<td>$250 per admission deductible after Calendar Year deductible, then the plan pays 70%</td>
<td>90% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td>Physician Services</td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
<td>80% per visit after Calendar Year deductible</td>
</tr>
</tbody>
</table>

| **Outpatient Treatment Of Mental Disorders** | | | |
| **Outpatient Services** | $10 per visit copay then the plan pays 100% | 70% per visit after Calendar Year deductible | 80% per visit after Calendar Year deductible |

| **Inpatient Treatment of Substance Abuse**<br>(GR-9N-5-10-062-01 DE) | | | |
| **Hospital Facility Expense** | | | |
| Room and Board | 90% per admission after Calendar Year deductible | $250 per admission deductible after Calendar Year deductible, then the plan pays 70% | 90% per admission after Calendar Year deductible |
| Other than Room and Board | 90% per admission after Calendar Year deductible | 70% per admission after Calendar Year deductible | 80% per admission after Calendar Year deductible |
| Physician Services | 90% per visit after Calendar Year deductible | 70% per visit after Calendar Year deductible | 80% per visit after Calendar Year deductible |

| **Inpatient Residential Treatment**<br>(GR-9N-5-10-062-01 DE) | | | |
| Facility Expenses | 90% per admission after Calendar Year deductible | $250 per admission deductible after Calendar Year deductible, then the plan pays 70% | 90% per admission after Calendar Year deductible |
| Physician Services | 90% per visit after Calendar Year deductible | 70% per visit after Calendar Year deductible | 80% per visit after Calendar Year deductible |
### PLAN FEATURES

#### NETWORK
*(In the U.S.)*

<table>
<thead>
<tr>
<th>Outpatient Treatment of Alcoholism and Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Treatment</strong></td>
</tr>
</tbody>
</table>

No Calendar Year **deductible** applies.

#### OUTSIDE THE U.S.

### PLAN FEATURES

#### NETWORK
*(IOE Facility)* *(In the U.S.)*

| Transplant Services Facility and Non-Facility Expenses *(GR 9N S-10.075.01)* |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| **Transplant Facility Expenses** | 90% per admission after Calendar Year **deductible** | $250 per admission **deductible** after Calendar Year **deductible**, then the plan pays 70% | $250 per admission **deductible** after Calendar Year **deductible**, then the plan pays 70% |
| **Transplant Physician Services** *(including office visits)* | Payable in accordance with the type of expense incurred and the place where service is provided | Payable in accordance with the type of expense incurred and the place where service is provided | Payable in accordance with the type of expense incurred and the place where service is provided |

### PLAN FEATURES

#### NETWORK
*(Non-IOE Facility)* *(In the U.S.)*

<table>
<thead>
<tr>
<th>Other Covered Health Expenses <em>(GR 9N S-10.080.02 DE)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture in lieu of anesthesia</strong></td>
</tr>
</tbody>
</table>

| **Ground, Air or Water Ambulance** | 90% per trip after Calendar Year **deductible** | 70% per trip after Calendar Year **deductible** | 80% per trip after Calendar Year **deductible** |

| **Diabetic Equipment, Supplies and Education** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |

<p>| <strong>Durable Medical and Surgical Equipment</strong> | 90% per item after Calendar Year <strong>deductible</strong> | 70% per item after Calendar Year <strong>deductible</strong> | 80% per item after Calendar Year <strong>deductible</strong> |</p>
<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK (In the U.S.)</th>
<th>OUT-OF-NETWORK (In the U.S.)</th>
<th>OUTSIDE THE U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Covered Health Expenses (cont’d)</strong> (GR 9N S.10-080-02 DE)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Covered under Pharmacy Benefit</td>
<td>70% per prescription after Calendar Year deductible</td>
<td>80% per prescription after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Orthotic and Prosthetic Devices</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Scalp Hair Prosthesis</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Outpatient Therapies</strong> (GR 9N S.10-80-01)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK (In the U.S.)</td>
<td>OUT-OF-NETWORK (In the U.S.)</td>
<td>OUTSIDE THE U.S.</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>------------------------</td>
<td>------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Short Term Outpatient Rehabilitiation Therapies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Physical, Occupational, and Speech Therapy combined</strong></td>
<td>$10 per visit <strong>copay</strong> then the plan pays 100%</td>
<td>70% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>60 visits</td>
<td>60 visits</td>
<td>60 visits</td>
</tr>
<tr>
<td><strong>Spinal Manipulation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Spinal Manipulation</strong></td>
<td>$10 per visit <strong>copay</strong> then the plan pays 100%</td>
<td>75% per visit after Calendar Year <strong>deductible</strong></td>
<td>80% per visit after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Autism Spectrum Disorder</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(GR-9N 10-061-03 DE)</strong></td>
<td>Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.</td>
<td>Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.</td>
<td>Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.</td>
</tr>
<tr>
<td><strong>Global Emergency Assistance Program</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unlimited Calendar Year Maximum)</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
</tr>
</tbody>
</table>
### Generic Prescription Drugs

<table>
<thead>
<tr>
<th>Copays</th>
<th>PER PRESCRIPTION COPAY</th>
<th>NETWORK (In the U.S.)</th>
<th>OUT-OF-NETWORK (In the U.S.)</th>
<th>OUTSIDE THE U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>One copay for each 31 day supply (retail) (12 copay maximum)</td>
<td>$10 copay</td>
<td>Covered under Medical Benefit</td>
<td>Covered under Medical Benefit</td>
<td></td>
</tr>
<tr>
<td>365 days maximum supply.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One copay for each 31 day supply (mail order) (12 copay maximum)</td>
<td>$10 copay</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>365 days maximum supply.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Brand-Name Prescription Drugs

<table>
<thead>
<tr>
<th>Copays</th>
<th>PER PRESCRIPTION COPAY</th>
<th>NETWORK (In the U.S.)</th>
<th>OUT-OF-NETWORK (In the U.S.)</th>
<th>OUTSIDE THE U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>One copay for each 31 day supply (retail) (12 copay maximum)</td>
<td>$20 copay</td>
<td>Covered under Medical Benefit</td>
<td>Covered under Medical Benefit</td>
<td></td>
</tr>
<tr>
<td>365 days maximum supply.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One copay for each 31 day supply (mail order) (12 copay maximum)</td>
<td>$20 copay</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>365 days maximum supply.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK (In the U.S.)</td>
<td>OUT-OF-NETWORK (In the U.S.)</td>
<td>OUTSIDE THE U.S.</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------</td>
<td>-----------------------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care Drugs and Supplements</strong></td>
<td>100% per item.</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Preventive care drugs and supplements filled at a pharmacy with a prescription:</td>
<td>No copay or deductible applies.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Important Note:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer to the Booklet-Certificate for a complete description of the preventive care drugs and supplements covered under this Plan and for limitations that apply to these benefits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco cessation prescription and over-the-counter drugs</strong></td>
<td>100% per item.</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Tobacco cessation prescription drugs and OTC drugs filled at a retail pharmacy.</td>
<td>No copay or deductible applies.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each 30–90 day supply</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximums: Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, Member Services by logging onto your Aetna Navigate® secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Coinsurance

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK (In the U.S.)</th>
<th>OUT-OF-NETWORK (In the U.S.)</th>
<th>OUTSIDE THE U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drug Plan Coinsurance</td>
<td>100% of the negotiated charge</td>
<td>Covered under Medical Benefit</td>
<td>Covered under Medical Benefit</td>
</tr>
</tbody>
</table>

The prescription drug plan coinsurance is the percentage of prescription drug covered expenses that the plan pays after any applicable deductibles and copays have been met.

Mail Order only mails to locations in the United States.

Expense Provisions (GR-9N-S-09-05-01 DE)

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.

The insurance described in this Schedule of Benefits will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Deductible Provisions (GR-9N-S-09-05-01 DE)

Network Calendar Year Deductible
This is an amount of network covered expenses incurred each Calendar Year for which no benefits will be paid. The network Calendar Year deductible applies separately to you and each of your covered dependents. 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 Calendar Year Deductible
This is an amount of out-of-network covered expenses incurred each Calendar Year for which no benefits will be paid. The out-of-network Calendar Year deductible applies separately to you and each of your covered dependents. 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.

Covered expenses applied to the out-of-network deductible will be applied to satisfy the network deductible and covered expenses applied to the network deductible will be applied to satisfy the out-of-network deductible.

Network Family Deductible Limit
When you incur network covered expenses that apply toward the network Calendar Year deductibles for you and each of your covered dependents these expenses will also count toward the network Calendar Year family deductible limit. Your network family deductible limit will be considered to be met for the rest of the Calendar Year once the combined covered expenses reach the network family deductible limit in a Calendar Year.

Out-of-Network Family Deductible Limit
When you incur out-of-network covered expenses that apply toward the out-of-network Calendar Year deductibles for you and each of your covered dependents these expenses will also count toward the out-of-network Calendar Year family deductible limit. Your out-of-network family deductible limit will be considered to be met for the rest of the Calendar Year once the combined covered expenses reach the out-of-network family deductible limit in a Calendar Year.

Covered expenses applied to the out-of-network deductible will be applied to satisfy the network deductible and covered expenses applied to the network deductible will be applied to satisfy the out-of-network deductible.
Copayments and Benefit Deductible Provisions (GR.9N:09.015-01 DE)

Copayment, Copay
This is a specified dollar amount or percentage of the negotiated charge required to be paid by you at the time you receive a covered service from a network provider. It represents a portion of the applicable expense.

Per Admission Deductible
A Per Admission Deductible is a specified dollar amount for which no benefit is paid when you or a covered dependent have a stay in an inpatient facility.

Separate deductibles may apply per facility. These deductibles are in addition to any other deductible applicable under this plan. They may apply to each stay or they may apply on a per day basis up to a per admission maximum amount. Not more than three per admission deductibles will apply for each facility type during a Calendar Year.

Covered expenses applied to the per admission deductible cannot be applied to any other or deductible required in your plan. Likewise, covered expenses applied to your plan’s other deductibles cannot be applied to meet the per admission deductible.

For the stay of a well newborn baby (starting at birth), the per admission deductible amount will not exceed the hospital’s actual room and board charge on the first day of the stay.

Coinsurance Provisions (GR.9N S-09.020 01)

Coinsurance
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 Coinsurance”. 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 coinsurance percentage may vary by the type of expense. Refer to your Schedule of Benefits for coinsurance amounts for each covered benefit.

Maximum Out-of-Pocket-Limit
The Maximum Out-of-Pocket-Limit is the maximum amount you are responsible to pay for covered expenses during the Calendar Year. 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. The Maximum Out-of-Pocket-Limit applies to network, out-of-network and outside the United States benefits.

This plan has an Individual Maximum Out-of-Pocket-Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual Maximum Out-of-Pocket-Limit, the plan will pay 100% of covered expenses for the remainder of the Calendar Year for that person.

There is also a Family Maximum Out-of-Pocket-Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets three times the individual Maximum Out-of-Pocket-Limit, 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 network, out-of-network and outside the United States 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.

Covered expenses that are subject to the Maximum Out-of-Pocket Limit include prescription drug expenses provided under the Medical or Prescription drug Plans, as applicable.
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;
- Any covered expenses which are payable by Aetna at 50%; 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. (Applies in the United States)

Precertification Benefit Reduction (Applies in the United States) (GR-9N S-09-30 01)

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

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

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

General (GR-9N-28-01-01-DE)

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-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.
BENEFIT PLAN

Prepared Exclusively For
Adobe Systems Incorporated

Comprehensive Dental

Aetna Life Insurance Company
Booklet-Certificate

What Your Plan
Covers and How
Benefits are Paid

This Booklet-Certificate is part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder
ID Cards
If you are an enrollee with Aetna Dental coverage, you don't need an ID card. When visiting a dentist, simply provide your name, date of birth and Member ID# (or social security number). The dental office can use that information to verify your eligibility and benefits. If you still would like an ID card for you and your dependents, you can print a customized ID card by going to the secure member website at www.aetnainternational.com. You can also access your benefits information when you’re on the go. To learn more, visit us at www.aetna.com/mobile or call us at 1-877-238-6200.
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Issued With Your Booklet
Aetna Life Insurance Company (ALIC) is pleased to provide you with this Booklet-Certificate. Read this Booklet-Certificate carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as Aetna).

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

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

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

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Group Policyholder: Adobe Systems Incorporated
Control Number: 447926
Effective Date: January 1, 2016
Issue Date: February 1, 2016
Booklet-Certificate Number: 3

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)
Important Information Regarding Availability of Coverage (GR-9N 02-005 02)

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

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

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

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

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

Benefits may be modified during the term of this plan as specifically provided under the terms of the Group Insurance Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the Group Insurance Policy or in this Booklet-Certificate beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.
Coverage for You and Your Dependents (GR-9N-02-005-01 DE)

Health Expense Coverage (GR-9N-02-020-01 DE)

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

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

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

Treatment Outcomes of Covered Services (GR-9N-02-020-01 DE)

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

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.

Determining if You Are in an Eligible Class (GR.9N.29.005-02)
You are in an eligible class if:

- You are a regular full-time employee of Adobe Systems Incorporated participating in this plan working a minimum of 25 hours per week and you elected coverage under the plan.

Determining When You Become Eligible (GR.9N.29.005-02)
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 (GR.9N 29.010.01)
Your dependents can be covered under your plan. You may enroll the following dependents:

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

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.
Coverage for Domestic Partner *(GR.9N 29.010.01)*
A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past six months.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she has cohabitated and resided with you in the same residence for the past six months and intends to cohabit and reside with you indefinitely.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
  - Common ownership of a motor vehicle;
  - Driver’s license listing a common address;
  - Proof of joint bank accounts or credit accounts;
  - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
  - Assignment of a durable property power of attorney or health care power of attorney.

Coverage for Dependent Children *(GR.9N.29.010.06 DE)*
To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child 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 this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.
How and When to Enroll (GR-9N 29:015-02)

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 31 days of your eligibility date.

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.

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

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 the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period.

When Your Coverage Begins (GR-9N 29:025:01 DE)

Your Effective Date of Coverage
Your coverage takes effect on the date you are eligible for coverage

Your Dependent’s Effective Date of Coverage
Your dependent’s coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan by then.

Note: New dependents need to be reported to Aetna within 31 days because they may affect your contributions.
Requirements For Coverage (GR-9N-09-005-01 DE)

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

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

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

3. The service or supply must be medically necessary. To meet this requirement, the dental service or supply must be provided by a physician, or other health care provider or dental 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:
   - In accordance with generally accepted standards of dental practice;
   - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
   - Not primarily for the convenience of the patient, physician or dental provider or other health care provider;
   - 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 dental practice” means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant 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.

Important Note
- Not every service or supply that fits the definition for medical necessity is covered by the plan. Exclusions and limitations apply to certain dental 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.
How Your Aetna Dental Plan Works

(Gr-9N 16-005-01)

Understanding Your Aetna Dental Plan

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

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What 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".

This Booklet-Certificate applies to coverage only and does not restrict your ability to receive covered expenses that are not or might not be covered expenses under this dental plan.

Store this Booklet-Certificate in a safe place for future reference.

Getting Started: Common Terms (Gr-9N 16-010-01)

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

About the Comprehensive Dental Plan (Gr-9N 16-030 01)

This dental plan covers a wide range of necessary dental services and supplies. You have the freedom to choose the dental provider of your choice.

The comprehensive dental plan begins to pay benefits after you satisfy a deductible.

You share the cost of covered services and supplies by paying a portion of certain expenses (your coinsurance).

If your dentist charges more than the recognized charge, you must also pay any expenses above the recognized charge.

You must file a claim to receive reimbursement from the plan.

Important Reminder

Refer to the Schedule of Benefits for details about any applicable deductibles, coinsurance and maximum benefit limits.
Getting an Advance Claim Review  (GR-9N-16-035-01)

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for proposed services. Knowing ahead of time which services are covered by the plan, and the benefit amount payable, helps you and your dentist make informed decisions about the care you are considering.

Important Note
The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review
An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $350. Ask your dentist to write down a full description of the treatment you need, using either an Aetna claim form or an ADA approved claim form. Then, before actually treating you, your dentist should send the form to Aetna. Aetna may request supporting x-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your dentist with a statement outlining the benefits payable by the plan. You and your dentist can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your dentist can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, Aetna will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. (See Benefits When Alternate Procedures Are Available for more information on alternate dental procedures.)

What is a Course of Dental Treatment?
A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more dentists to treat a dental condition that was diagnosed by the attending dentist as a result of an oral examination. A course of treatment starts on the date your dentist first renders a service to correct or treat the diagnosed dental condition.

What The Plan Covers  (GR-9N 18-005-01)

Comprehensive Dental Plan
Schedule of Benefits for the Comprehensive Dental Plan
Comprehensive Dental is merely a name of the benefits in this section. The plan does not pay a benefit for all dental care expenses you incur.

Important Reminder
Your dental services and supplies must meet the following rules to be covered by the plan:

- The services and supplies must be medically necessary.
- The services and supplies must be covered by the plan.
- You must be covered by the plan when you incur the expense.

Covered expenses include charges made by a dentist for the services and supplies that are listed in the dental care schedule as shown in the Schedule of Benefits.
The next sentence applies if:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one of more services that, under standard practices, are separately suitable for the dental care of that condition.

In that case, the charge will be considered to have been made for a service in the list that Aetna determines would have produced a professionally acceptable result.

**Dental Care Schedule**

The dental care schedule is a list of dental expenses that are covered by the plan. There are several categories of covered expenses:

- Preventive
- Diagnostic
- Restorative
- Oral surgery
- Endodontics
- Periodontics
- Orthodontics

These covered services and supplies are grouped as Type A, Type B or Type C.

**Comprehensive Dental Expense Coverage Plan (GR-9N 18-006-01)**

The following additional dental expenses will be considered covered expenses for you and your covered dependent if you have medical coverage insured or administered by Aetna and have at least one of the following conditions:

- Pregnancy;
- Coronary artery disease/cardiovascular disease;
- Cerebrovascular disease; or
- Diabetes

**Additional Covered Dental Expenses**

- One additional prophylaxis (cleaning) per year.
- Scaling and root planing, (4 or more teeth); per quadrant;
- Scaling and root planing (limited to 1-3 teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance (one additional treatment per year); and
- Localized delivery of antimicrobial agents. (Not covered for pregnancy)

**Payment of Benefits**

The additional prophylaxis, the benefit will be payable the same as other prophylaxis under the plan.

The plan coinsurance applied to the other covered dental expenses above will be 100%. These additional benefits will not be subject to any frequency limits except as shown above or any Calendar Year maximum.

Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for covered expenses.

**Important Reminder (GR-9N-18-010-01)**

The deductible, coinsurance and maximums that apply to each type of dental care are shown in the Schedule of Benefits.
Type A Expenses: Diagnostic and Preventive Care

**Visits and X-Rays**
Office visit during regular office hours, for oral examination
- Routine comprehensive or recall examination (limited to 2 visits every year)
- Problem-focused examination (limited to 2 visits every year)
Prophylaxis (cleaning) (limited to 2 treatments per year)
  - Adult
  - Child
Topical application of fluoride, (limited to one course of treatment per year and to children under age 16)
Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 16)
Bitewing X-rays (limited to 1 set per year)
Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
Vertical bitewing X-rays (limited to 1 set every 3 years)
Periapical x-rays (single films up to 13)

**Space Maintainers** Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)

Type B Expenses: Basic Restorative Care

**Visits and X-Rays**
Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
Emergency palliative treatment, per visit

**X-Ray and Pathology**
- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and histopathologic examination of oral tissue

**Oral Surgery**
- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants
  - Surgical removal of erupted tooth/root tip
- Impacted Teeth
  - Removal of tooth (soft tissue)
- Odontogenic Cysts and Neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor
- Other Surgical Procedures
  - Alveoplasty, in conjunction with extractions - per quadrant
  - Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Alveoplasty, not in conjunction with extraction - per quadrant
  - Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Sialolithotomy: removal of salivary calculus
  - Closure of salivary fistula
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Transplantation of tooth or tooth bud
  - Closure of oral fistula of maxillary sinus
  - Sequestrectomy
Crown exposure to aid eruption
Removal of foreign body from soft tissue
Frenectomy
Suture of soft tissue injury

**Periodontics**
Occlusal adjustment (other than with an appliance or by restoration)
Root planning and scaling, per quadrant (limited to 4 separate quadrants every 2 years)
Root planning and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 3 years
Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
Periodontal maintenance procedures following active therapy (limited to 2 per year)
Localized delivery of antimicrobial agents

**Endodontics**
Pulp capping
Pulpotomy
Apexification/recalcification
Apicoectomy
Root canal therapy including necessary X-rays
  Anterior
  Bicuspid

**Restorative Dentistry** Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges.
(Multiple restorations in 1 surface will be considered as a single restoration.)
Amalgam restorations
Resin-based composite restorations (other than for molars)
Pins
  Pin retention—per tooth, in addition to amalgam or resin restoration
Crowns (when tooth cannot be restored with a filling material)
  Prefabricated stainless steel
  Prefabricated resin crown (excluding temporary crowns)
Recementation
  Inlay
  Crown
  Bridge

**Type C Expenses: Major Restorative Care**

**Oral Surgery**
Surgical removal of impacted teeth
  Removal of tooth (partially bony)
  Removal of tooth (completely bony)

**Periodontics**
Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 years
Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 3 years
Soft tissue graft procedures
Clinical crown lengthening, hard tissue
Full mouth Debridement

**Endodontics**
Root canal therapy Including necessary X-rays
  Molar
Restorative. Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 8 years- see Replacement Rule).

Inlays/Onlays
Labial Veneers
- Laminate-chairside
- Resin laminate – laboratory
- Porcelain laminate – laboratory

Crowns
- Resin
- Resin with noble metal
- Resin with base metal
- Porcelain/ceramic substrate
- Porcelain with noble metal
- Porcelain with base metal
- Base metal (full cast)
- Noble metal (full cast)
- 3/4 cast metallic or porcelain/ceramic

Post and core
Core build up, including any pins

Prosthodontics- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 8 years old. (See Tooth Missing But Not Replaced Rule.) Replacement of existing bridges or dentures is limited to 1 every 8 years. (See Replacement Rule.)

Bridge Abutments (See Inlays and Crowns)
Pontics
- Base metal (full cast)
- Noble metal (full cast)
- Porcelain with noble metal
- Porcelain with base metal
- Resin with noble metal
- Resin with base metal

Removable Bridge (unilateral)
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics

Dentures and Partial (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
- Complete upper denture
- Complete lower denture
- Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
- Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Office reline
- Laboratory reline
- Special tissue conditioning, per denture
- Rebase, per denture
- Adjustment to denture more than 6 months after installation

Full and partial denture repairs
- Broken dentures, no teeth involved
- Repair cast framework
- Replacing missing or broken teeth, each tooth
Adding teeth to existing partial denture
   Each tooth
   Each clasp
Reparations: crowns and bridges
Occlusal guard (for bruxism only), limited to 1 every 3 years

General Anesthesia and Intravenous Sedation (only when medically necessary and only when provided in conjunction with a covered surgical procedure)

Orthodontics
Interceptive orthodontic treatment
Limited orthodontic treatment
Comprehensive orthodontic treatment of adolescent dentition
Comprehensive orthodontic treatment of adult dentition
Post treatment stabilization
Removable appliance therapy to control harmful habits
Fixed appliance therapy to control harmful habits

Rules and Limits That Apply to the Dental Plan (GR-9N 20-005-01)

Several rules apply to the dental plan. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

Orthodontic Treatment Rule
The plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

The plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the plan.

Orthodontic Limitation for Late Enrollees
The plan will not cover the charges for an orthodontic procedure for which an active appliance for that procedure has been installed within the two year-period starting with the date you became covered by the plan. This limit applies only if you do not become enrolled in the plan within 31 days after you first become eligible.

Replacement Rule (GR-9N 20-010-01)
Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to Aetna that:

- While you were covered by the plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 8 years before its replacement and cannot be made serviceable.
You had a tooth (or teeth) extracted while you were covered by the plan. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

**Tooth Missing but Not Replaced Rule**
The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the plan; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 8 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

**Alternate Treatment Rule** *(GR-9N-20-015-01)*
Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

**Coverage for Dental Work Begun Before You Are Covered by the Plan** *(GR-9N 20-020-01)*
The plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan;
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan; or
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan.

**Coverage for Dental Work Completed After Termination of Coverage**
Your dental coverage may end while you or your covered dependent is in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.
Ordered" means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

**Late Entrant Rule (GR-9N 20425-01)**

The plan does not cover services and supplies given to a person age 5 or more if that person did not enroll in the plan:

- During the first 31 days the person is eligible for this coverage, or
- During any period of open enrollment agreed to by the Policyholder and Aetna.

This exclusion does not apply to charges incurred:

- After the person has been covered by the plan for 12 months, or
- As a result of injuries sustained while covered by the plan, or
- For services listed as Visits and X-rays, Visits and Exams, and X-ray and Pathology in the Dental Care Schedule.

**What The Comprehensive Dental Plan Does Not Cover (GR-9N 28025-01-DE)**

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What the Plan Covers section or by amendment attached to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These dental exclusions are in addition to the exclusions that apply to health coverage.

Any instruction for diet, plaque control and oral hygiene.

Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the What the Plan Covers section.

Crown, inlays and onlays, and veneers unless:

- It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
- The tooth is an abutment to a covered partial denture or fixed bridge.

Dental implants, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder.

Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.
Except as covered in the *What the Plan Covers* section, treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.

General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.

**Orthodontic treatment** except as covered in the *What the Plan Covers* section.

Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).

Prescribed drugs; pre-medication; or analgesia.

Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

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

Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:

- Scaling of teeth; and
- Cleaning of teeth.

**Additional Items Not Covered By A Health Plan** (GR-9N-28.015.01-DE)

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

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

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

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

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

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

- Any dental 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.

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:

- 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; or
  - Care while in the custody of a governmental authority.

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*.

Routine dental exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet-Certificate.

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 health plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, Aetna may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not actively at work due to illness or injury, your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

It is your employer’s responsibility to let Aetna know when your employment ends. The limits above may be extended only if Aetna and your employer agree, in writing, to extend them.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents’ coverage;
- You do not make your contribution for the cost of dependents’ coverage;
- Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan’s definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

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

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See Continuation of Coverage for more information.
Continuation of Coverage (GR.9N-31-010-03)

Continuing Health Care Benefits (GR.9N-31-015-06)

Continuing Coverage for Dependent Students on Medical Leave of Absence (GR.9N-31-015-01)
If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious illness or injury, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. Aetna may require a written certification from the treating physician which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or change in full-time student status) is medically necessary.

Important Note
If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, Handicapped Dependent Children, for more information.

Handicapped Dependent Children (GR.9N-31-015-01)
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 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

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

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

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

Coverage for Health Benefits
If your health benefits end while you are totally disabled, your health expenses will be extended as described below, but, with respect to medical benefits, only as to expenses incurred in connection with the injury or illness that caused the total disability. To find out why and when your coverage may end, please refer to When Coverage Ends.

“Totally disabled” means that because of an injury or illness:

▪ You are not able to work at your own occupation and you cannot work at any occupation for pay or profit.
▪ Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage (GR-9N 31-020 01)

Dental Benefits (other than Basic Dental benefits): Coverage will be available while you are totally disabled, for up to 12 months. Coverage will be available only if covered services and supplies have been rendered and received, including delivered and installed, prior to the end of that 12 month period.

When Extended Health Coverage Ends
Extension of benefits will end on the first to occur of the date:

▪ You are no longer totally disabled, or become covered under any other group plan with like benefits.
▪ Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

COBRA Continuation of Coverage

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

Continuing Coverage through COBRA
When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.
You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer’s notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

**Who Qualifies for COBRA**

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

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

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<tr>
<th>Qualifying Event Causing Loss of Health Coverage</th>
<th>Covered Persons Eligible to Elect Continuation</th>
<th>Maximum Continuation Periods</th>
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<td>You and your dependents</td>
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<tr>
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<td>You divorce or legally separate and are no longer responsible for dependent coverage</td>
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<td>You and your dependents</td>
<td>18 months</td>
</tr>
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</table>

**Disability May Increase Maximum Continuation to 29 Months**

*If You or Your Covered Dependents Are Disabled.*

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

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

*If There Are Multiple Qualifying Events.*

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

Your premium payments are regulated by law, based on the following:

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

**When You Acquire a Dependent During a Continuation Period**

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

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

**Important Note**

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

**When Your COBRA Continuation Coverage Ends**

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

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

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. “Plan” and “This plan” are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Which Plan Pays First (GR-9N-33-010-01)

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

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      i. The parents are married or living together whether or not married;
      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   B. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child’s health care expenses, but that parent’s spouse does, the plan of the parent’s spouse is the primary plan.
   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
      – The plan of the custodial parent;
      – The plan of the spouse of the custodial parent;
      – The plan of the noncustodial parent; and then
      – The plan of the spouse of the noncustodial parent.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

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

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

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

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

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of This Plan, the amount normally reimbursed for covered benefits or expenses under This Plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under This Plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of This Plan and another plan both agree that This Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

**Right To Receive And Release Needed Information**

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

**Facility of Payment**

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

**Right of Recovery**

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

This section explains how the benefits under This Plan interact with benefits available under Medicare.

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

You are eligible for Medicare if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease.

If you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, the plan is the primary payor, which means that the plan pays benefits before Medicare pays benefits. Under other circumstances, the plan is the secondary payor, and pays benefits after Medicare.

Which Plan Pays First

The plan is the primary payor when your coverage for the plan’s benefits is based on current employment with your employer. The plan will act as the primary payor for the Medicare beneficiary who is eligible for Medicare:

- Solely due to age if the plan is subject to the Social Security Act requirements for Medicare with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits. This provision does not apply if, at the start of eligibility, you were already eligible for Medicare benefits, and the plan’s benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the plan meets the definition of a large group health plan as outlined in the Internal Revenue Code i.e., generally a plan of an employer with 100 or more employees.

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary
The plan pays benefits first when it is the primary payor. You may then submit your claim to Medicare for consideration.

When Medicare is Primary
Your health care expense must be considered for payment by Medicare first. You may then submit the expense to Aetna for consideration.

Aetna will calculate the benefits the plan would pay in the absence of Medicare:

The amount will be reduced so that when combined with the amount paid by Medicare, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total allowable expense.
This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under Medicare will be applied under the plan in the order received by Aetna. Aetna will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

**Right to Receive and Release Required Information**

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under This Plan and other plans. Aetna has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.
General Provisions
(GR-9N 32005 02 DE)

Type of Coverage

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

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will also include the right and opportunity to make an autopsy in the case of death where it is not prohibited by law. This will be done at no cost to you.

Legal Action

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

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

Confidentiality

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

Additional Provisions

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- 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 policy. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or Aetna.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.
Assignments (GR-9N 32-005 02 DE)

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

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

Misstatements (GR-9N-32-005-03)

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

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

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

Incontestability

As to Accident and Health Benefits:

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

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

Recovery of Overpayments (GR-9N-32-015-01 DE)

Health Coverage

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

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

Such right does not affect any other right of recovery Aetna may have with respect to such overpayment.
Reporting of Claims (GR-9N-32-015-01 DE) (GR-9N-32-015-01 DE)

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

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

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. 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 (GR-9N-32-025-02)

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.

Any unpaid balance will be paid within 30 days of receipt by Aetna of the due written proof.

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

Records of Expenses (GR-9N-32-030-02)

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

Very important are:

- Names of dentists 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
Attention: Aetna International
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.aetnainternational.com.
Effect of Benefits Under Other Plans (GR-9N 32:035:01)

Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage
If you are in an eligible class and have chosen dental coverage under an HMO Plan offered by your employer, you will be excluded from dental expense coverage on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan providing dental coverage, 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 dental 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 dental 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 dental coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when Aetna gives its written consent.

Any extension of dental benefits under this plan will not apply on or after the date of a change to an HMO Plan.

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

Effect of Prior Coverage - Transferred Business (GR-9N 32:040 02 DE)
If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

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

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

coverage under this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided under the section, Continuing Coverage for Dependent Students on Medical Leave of Absence.
Discount Programs *(GR-9N 3204501)*

**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 healthy 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 (GR-9N 3204501)**

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.
Appeals Procedure (GR-9N-32-050-01 DE)

Definitions

Adverse Benefit Determination (Decision): 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.
- 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.
- A decision that the service or supply is not medically necessary.

An adverse benefit determination also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

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

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

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

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

External Review: A review of an adverse benefit determination or a final adverse benefit determination by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner and made up of physicians or other appropriate health care providers. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An adverse benefit determination that has been upheld by Aetna at the exhaustion of the appeals process.

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:

- Seriously jeopardize your life or health;
- 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.

Full and Fair Review of Claim Determinations and Appeals

As to medical and prescription drug claims and appeals only, Aetna will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the final adverse benefit determination is required to be provided so that you may respond prior to that date.
Prior to issuing a final adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of final adverse determination is required.

Claim Determinations
Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and prescription drug claims only, if Aetna makes an adverse benefit determination, written notice will be provided to you, or in the case of a concurrent care claim, to your provider.

Urgent Care Claims
Aetna will notify you of an urgent care claim decision as soon as possible, but not later than 72 hours after the claim is made.

If more information is needed to make an urgent claim decision, Aetna will notify the claimant within 72 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 to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the physician to provide Aetna with the information.

Pre-Service Claims
Aetna will notify you of a pre-service claim decision as soon as possible, but not later than 15 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar day claim decision 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 day period. If this extension is needed because Aetna needs more information to make a claim decision, 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 notify you of a post-service claim decision as soon as possible, but not later than 30 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim decision 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 more information to make a claim decision, 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 notify you of a claim decision for urgent care as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 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 notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal.

If you file an appeal, coverage under the plan will continue for the previously approved course of treatment until a final appeal decision is rendered. During this continuation period, you are responsible for any copayments, coinsurance, and deductibles; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under appeal. If Aetna's initial claim decision is upheld in the final appeal decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints
If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Member Services. The complaint 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 more 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 depending upon the type of coverage provided under the Plan. A final adverse benefit determination notice will also provide an option to request an External Review (if available).

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an adverse benefit determination to request your Level One Appeal. Your appeal may be submitted orally or in writing and must include:

- Your name.
- The employer's name.
- A copy of Aetna's notice of an adverse benefit determination.
- Your reasons for making the appeal.
- Any other information you would like to have considered.

Send your written appeal to Member Services at the address shown on your ID Card, or call in your appeal to Member Services using the telephone number shown on your ID card.

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

You may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.
Level One Appeal
A review of a Level One Appeal of an adverse benefit determination shall be provided by Aetna personnel. They shall not have been 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 22 calendar days of receipt of the request for an appeal.

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

Review of 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. They shall not have been 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 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 a Level Two Appeal.

Post-Service Claims
Aetna shall issue a decision within 23 calendar days of receipt of the request for a Level Two Appeal.

Aetna may extend the Utilization Management Appeal review for up to an additional thirty (30) calendar days for reasonable cause by submitting a written explanation for the delay to the Delaware Department of Insurance within the original thirty (30) calendar review period. In no event, may Aetna extend the review period for an Urgent Care Claim or Concurrent Care Claim Extension.

In the event Aetna fails to comply with any of the above Level 1 or Level 2 Utilization Management Appeal timeframes, or in the event Aetna waives its rights to review an Utilization Management Appeal, you shall be relieved of your obligation to complete the two levels of Utilization Management Appeal, and at your option, may proceed directly to the External Utilization Management Appeal process.

You and/or an authorized representative may attend the Level Two Appeal hearing and question the representative of Aetna and/or any other witnesses, and present their case. Aetna shall acknowledge receipt of all Level 2 Utilization Management Appeals in writing to you. This acknowledgement shall include the place, date and time of the Level 2 Appeal hearing and provide you with at least fifteen (15) calendar days notice of the Level 2 Appeal hearing. You may request a change in the hearing schedule to facilitate attendance. The hearing will be informal. Your physician or other experts may testify. Aetna also has the right to present witnesses.
Exhaustion of Process
You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- Contact the Delaware Department of Insurance to request an investigation of a complaint or appeal; or
- File a complaint or appeal with the Delaware Department of Insurance; or
- Establish any:
  - Litigation;
  - Arbitration; or
  - Administrative proceeding;

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

Under certain circumstances, you may seek simultaneous review through the internal Appeals Procedure and External Review processes—these include Urgent Care Claims and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

If Aetna does not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the appeal requirements and may proceed with External Review or any of the actions mentioned above. There are limits, though, on what sends a claim or appeal straight to an External Review.

Your claim or internal appeal will not go straight to External Review if:

- a rule violation was minor and isn’t likely to influence a decision or harm you;
- it was for a good cause or was beyond Aetna’s control; and
- it was part of an ongoing, good faith exchange between you and Aetna.
Independent Health Care Appeals Program (GR-9N-32-051-01 DE) (External Utilization Management Appeal Process)

1. Upon receipt of a Level 2 Utilization Management Appeal adverse benefit determination, if you are dissatisfied with the results, you may pursue a Utilization Management Appeal before an Independent Utilization Review Organization (IURO).

2. You must file the request for an Utilization Management Appeal with Aetna within four (4) months of receipt of the Adverse benefit determination from the Utilization Management Appeal process. Upon receipt of your request for an external review, Aetna shall fax or send an electronic copy of the Petition for External Review form within three (3) business days to the Delaware Department of Insurance and then follow with a hard copy of the request to the Department by mail.

3. Once the request for an external review is received by the Department, the Department will assign an approved IURO to conduct the external review and notify Aetna.

4. Within 5 calendar days of the assignment, the assigned IURO will notify you in writing by certified or registered mail (requesting delivery confirmation by the United States Postal Service), that the Utilization Management Appeal was accepted for external review. This notice will include a provision stating that you, within seven (7) calendar days of this written notice, may submit additional information and supporting document that you would like the IURO to consider when conducting the external review. Upon receipt of any information submitted by you, the assigned IURO shall forward the information to Aetna with in two (2) business days.

5. Within seven (7) business days after Aetna receives notice of the assigned IURO, Aetna shall provide the assigned IURO the documents and any information considered in making the Utilization Management Appeal adverse benefit determination. If Aetna fails to submit this documentation and information or fails to participate within the time specified, the assigned IURO may terminate the external review and make a decision, with the approval of the Department, to reverse the Utilization Management Appeal adverse benefit determination.

6. The external review may be terminated if Aetna decides to reverse its adverse benefit determination and provide coverage or payment for the health care service that is the subject of the Utilization Management Appeal. Immediately upon making this decision, Aetna will notify you, the assigned IURO and the Department in writing of its decision. Upon receipt of this written notice from Aetna, the assigned IURO shall terminate the external review.

7. Within forty-five (45) calendar days after the receipt of the request for external review, the assigned IURO will provide written notice to you (by certified or registered mail requesting delivery confirmation by the United States Postal Service), Aetna and the Department of its decision to uphold or reverse the Aetna adverse benefit determination.

8. The decision of the IURO is binding upon Aetna.

Expedited External Utilization Management Appeal Process

1. You may request an expedited external review with Aetna at the time you receive a final Level 2 adverse benefit determination from Aetna if you suffer from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition.

2. At the time Aetna receives a request for an expedited external review, Aetna shall immediately fax or send an electronic copy of the Petition for External Review form to the Department and mail a hard copy of the form to the Department.

3. If the Department determines that the review meets the criteria for expedited review, the Department will assign an approved IURO to conduct the external review and notify Aetna. Upon receipt of the notification, Aetna will expeditiously provide or transmit all necessary documents and information considered in making the final adverse benefit determination.
4. Within seventy-two (72) after the date of the receipt of the request for an expedited external review, the IURO shall:

   a) Make a decision to uphold or reverse the final adverse benefit determination; and
   b) Immediately notify you, Aetna and the Department of the decision.
   c) Within two (2) calendar days of that notification, the IURO shall provide written confirmation of the decision to you, Aetna, and the Department.

5. The decision of the IURO is binding upon Aetna.
Glossary

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

A

**Aetna**

*Aetna* Life Insurance Company, an affiliate, or a third party vendor under contract with *Aetna*.

C

**Coinsurance**

Coinsurance is both the percentage of covered expenses that the plan pays, and the percentage of covered expenses that you pay. The percentage that the plan pays is referred to as "plan coinsurance" and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on coinsurance amounts.

**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.

D

**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*.

**Dental Provider**

This is:

- Any dentist;
- Group;
- Organization;
- Dental facility; or
- Other institution or person.

legally qualified to furnish dental services or supplies.

**Dentist**

A legally qualified dentist, or a physician licensed to do the dental work he or she performs.
Experimental or Investigational
Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

- There is not enough 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.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

that states that it is experimental or investigational, or for research purposes.

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.
I (GR-9N 34.045 02)

**Illness**
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

**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.

J (GR-9N 34.050 01)

**Jaw Joint Disorder** (GR-9N 34.050 01)
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L

**Lifetime Maximum**
This is the most the plan will pay for covered expenses incurred by any one covered person in their lifetime.

M (GR-9N 34.065 03 DE)

**Medically Necessary or Medical Necessity**
These are 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 give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an illness;
  - an injury;
  - a disease; or
  - its symptoms.

The provision of the service, supply or prescription drug must be:

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 mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same 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. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

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**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.

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**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.

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**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.

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**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.

**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.
Recognized Charge
The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider’s full charge.

Your plan’s recognized charge applies to all out-of-network covered expenses. In all cases, the recognized charge is determined based on the Geographic Area where you receive the service or supply.

- For dental expenses:
  - 80th percentile of the Prevailing Charge Rate

We have the right to apply Aetna reimbursement policies. Those policies may further reduce the recognized charge. These policies take into account factors such as:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow up care is included;
- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the provider.

Aetna reimbursement policies are based on our review of:
- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of physicians and dentists practicing in the relevant clinical areas.

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used
Geographic Area and Prevailing Charge Rates are defined as follows:

Geographic Area
The Geographic Area is made up of the first three digits of the U.S. Postal Service zip code. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic Area such as an entire state.

Prevailing Charge Rates
The percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, Aetna has the right to substitute an alternative database that Aetna believes is comparable.

Additional Information:
Get the most value out of your benefits. Use the “Estimate the Cost of Care” tool on Aetna Navigator to help decide whether to get care in network or out-of-network. Aetna’s secure member website at www.aetnainternational.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools.
R.N.
A registered nurse.

Skilled Nursing Facility
An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  - Professional nursing care by 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.

Specialist
A physician who practices in any generally accepted medical or surgical sub-specialty.

Specialist Dentist
Any dentist who, by virtue of advanced training is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry.

Specialty Care
Health care services or supplies that require the services of a specialist.
Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacists, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.
Additional Information Provided by
Adobe Systems Incorporated

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

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

**Name of Plan:**
Refer to your Plan Administrator for this information

**Employer Identification Number:**
Refer to your Plan Administrator for this information

**Plan Number:**
Refer to your Plan Administrator for this information

**Type of Plan:**
Welfare

**Type of Administration:**
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

**Plan Administrator:**
Adobe Systems Incorporated
Attention: Susan Burke - MGR, Vendor Partner Office
345 Park Avenue W07-431
San Jose CA 95110
Telephone Number: (408) 536-4433

**Agent For Service of Legal Process:**
Adobe Systems Incorporated
345 Park Avenue W07-431
San Jose CA 95110

Service of legal process may also be made upon the Plan Administrator

**End of Plan Year:**
December 31

**Source of Contributions:**
Employer and Employee

**Procedure for Amending the Plan:**
The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.
ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

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

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

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

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

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

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

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

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.
If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**
If you have any questions about your Plan, you should contact the Plan Administrator.

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

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

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 leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

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

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

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

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

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

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

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

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

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.
GLOBAL EMERGENCY ASSISTANCE PROGRAM
One call, one standard for managing emergencies while traveling abroad

Aetna International® (AI) provides international travelers with access to global emergency assistance resources that are available through a single call 24 hours a day, 7 days a week. AI provides access to the following emergency assistance services:

- **Emergency or Urgent Medical Evacuation**: Evacuation services may be necessary if a member or eligible dependent develops an emergency or urgent medical situation requiring immediate attention and adequate medical facilities are not locally available. The plan will cover payment of medically supervised evacuations to the closest facility capable of providing appropriate care.

- **Medical Repatriation Coordination**: Following an evacuation, the plan will cover payment for a one way economy fare to either the member's point of origin or to the permanent residence, or, if appropriate, to a facility as defined by the plan if it is medically advisable following patient stabilization. This may include any medically supervised transportation or medical treatment administered en route.

- **Return of Mortal Remains**: The benefit covers obtaining the necessary clearances for cremation or the return of member’s mortal remains in the event that the member dies while abroad, including coordination and plan-payment of expenses associated with cremation or preparation and return of remains.

- **Return of Dependent Children**: A plan-paid one-way economy air fare to the child’s permanent residence is covered when left unattended as a result of a member’s accident or illness. Coverage for a qualified attendant will also be provided, if required.

- **Companion Travel Coordination**: Following an evacuation, if a member is alone and hospitalized for more than seven (7) days, a plan-paid economy round-trip air fare to the place of hospitalization is covered for one person chosen by the member.

**Convalescent Lodging Coverage**: "Convalescent hotel expenses" are covered after evacuation and release from the hospital for illnesses or injury until member is fit to fly to return to point of origin. Also coverage is provided for accommodations for a family member to accompany a patient under the age of 18 after evacuation for hospitalization and convalescence only.

Medical necessity information (note from physician stating time period for convalescence) must be submitted with claims to support the length of time covered for convalescence. Receipts for any/all of the covered travel and lodging expenses must be received within six months of the date of service in order to be considered for reimbursement.

**Exclusions**:

- Meals
- Personal care items (e.g., shampoo, deodorant, etc.)
- Telephone calls
- Ground transportation

**Medical Assistance Services**

- **Pre-Trip Planning**: Assistance with up to date information either by email, fax or over the phone regarding required vaccinations, health risks, travel restrictions and weather conditions for worldwide destinations.

- **Medical, Dental and Pharmacy Referrals**: Members may request referrals to the most appropriate, nearby medical care resources, including preferred access to Aetna’s network of medical providers.

- **Dispatch of Medicine, Vaccines**: Assistance is available to obtain prescription medicine, vaccines, when not locally available and when legally permissible, upon the written authorization of member’s Primary Physician.

- **Dispatch of Physician/Nurse**: Dispatch to the member’s location a physician or other healthcare professional to assist in determining the medical condition and suitability to travel of a Member who has been hospitalized.

**NOTE**: All evacuations, returns to residence after stabilization, and/or repatriations of mortal remains are coordinated by and subject to the prior approval of Aetna International.
How To Take Advantage of Your Assistance Service Benefits:

Call the Global Emergency Assistance number on your ID card at 1-877-242-5580 if you or your eligible dependents:

- have a medical concern or question;
- are hospitalized or are about to be hospitalized;
- are involved in an accident requiring medical treatment;
- are having difficulty locating medical care;
- require translation services; or
- have other serious difficulties while located abroad.

If the condition is an emergency, you or your eligible dependents should go immediately to the nearest physician or hospital without delay and then contact AI. While Aetna International will do everything reasonably possible to direct you or your eligible dependents to the most appropriate care available once a call has been initiated, they are not responsible for the availability, quantity, quality or result of any medical treatment you may receive, or your failure to obtain medical treatment.

Global Emergency Assistance is available through AI 24 hours a day, 7 days a week, 365 days a year using the same telephone number from anywhere in the world.

You or your eligible dependents must always provide your Policy name and number and your name and Identification Number as the individual through which this group coverage has been made available. If you are not the individual seeking assistance, your eligible dependents must also provide their name.

The nature of the illness, injury, medical problem or emergency in question and the type of help that is needed should be explained to our intake coordinators at AI.

Expenses Not Covered Under the Global Emergency Assistance Program:

The Global Emergency Assistance Program shall not be responsible for the cost of services or expenses arising from:

- Your or your eligible dependents' suicide, attempted suicide, or willful self-inflicted injury, sexually transmittable diseases, or the abuse of drugs or alcoholic drink;
- Your or your eligible dependents' taking part in military or police service operations;
- The commission of or attempting to commit an unlawful act; or
- Aviation, except where you or your eligible dependents fly as a passenger in an aircraft properly licensed to carry passengers (except the Military Aircraft Command of the United States or similar air transport service of other countries.)
- You or your eligible dependents:
  - traveling against the advice of a physician;
  - traveling for the purposes of obtaining medical treatment; or
- Non-emergency expenses for routine or minor medical problems, tests, and exams where there is no clear or significant risk of death or imminent serious injury or harm to you or your eligible dependents.
- A condition which would allow for treatment at a future date convenient to you or your eligible dependents and which does not require emergency evacuation.
- Incidental expenses, including but not limited to, accommodations and meals incurred in connection with an emergency evacuation.
- Local emergency transportation expenses, including ground ambulance fees for you and your eligible dependents' initial transportation to local hospitals.
- Mountaineering or rock climbing necessitating the use of guide ropes, potholing, ballooning, motor racing, speed contests, skydiving, hang gliding, parachuting, spelunking, heli-skiing, extreme skiing or bungee cord jumping, deep sea diving utilizing hard helmet with air hose attachments, racing of any kind other than on foot and all professional sports.
Failure to contact AI in a timely manner may invalidate your eligibility for payment of transportation expenses. In addition, if the evacuation method or destination goes outside the boundaries of this program description, it may invalidate payment of subsequent transportation expenses.

Any bills incurred by you or your eligible dependents relating to assistance services must be submitted to AI in order to obtain payment consideration.

Note: As used throughout this section, the term "emergency" shall be defined to mean a situation when, in the professional opinion of your physician, a clear and significant risk of death or imminent serious injury or harm to you or your eligible dependents exists.
On-line Global Health and Travel Information from HTH Worldwide

Through an arrangement with HTH Worldwide (known as “HTH”), Aetna International ® (AI) can now offer you and your eligible dependents access to useful information specifically designed to help global employees and their families research and pursue quality health care virtually anywhere in the world. HTH is a leading provider of web-based health and travel information and services that are specifically tailored to help address the global needs of individuals living, working and traveling outside their home country.

By visiting the AI Member website http://www.aetnainternational.com you and your eligible dependents can access a suite of self-service, web based tools that may help you to be more self-reliant and better prepared for health related issues you may encounter during your international assignment.

Through AI’s online Member Service Center, you will have access to the important resources described in the following section(s).

What Types of Resources Are Available Through HTH?

Provider Community

International Provider Community – A community of over 2,500 English-speaking, pre-identified physicians, dentists, psychologists and other allied health professionals who are located in over 120 countries and who represent 24 medical specialties recognized by the American Board of Medical Specialties.

Providers are selected based on their professional qualifications, clinical experience, hospital affiliations, language skills, continuing medical education, peer recommendations, and positive experience with expatriate patients. Hand-selected providers must also have one of the following: verified current American Board of Medical Specialties certification; verified current Royal Medical or Surgical College membership (from the United Kingdom, Ireland, Canada, Australia, or New Zealand); and/or recommendation by HTH Regional Physician Advisors (RPA), HTH Medical Staff, and/or HTH Recruitment Partner.

In addition to professional qualification information, provider profiles also include ancillary details, which are verified 6 times annually, such as:
- Practice address and contact details
- Email address
- Language(s)
- Special Services (house calls, ambulance, onsite lab)
- Hospital Affiliations

Interactive/Online Tools

Provider search tool – This utility allows you to conduct a personalized on-line search of HTH’s International Provider Community to identify and research physicians and other providers that meet your geographic and medical specialty criteria. A convenient link is also provided to Aetna’s DocFind search engine, which provides information about the broad network of Aetna providers across the United States.

Health and Security Information

CityHealth Profiles™ - Information on the healthcare services in the world’s most frequent destinations for international assignees and business travelers. Valuable information that includes, but is not limited to the following, is presented at both a city and country level for more than 200 destinations outside of the United States:

- Notable hospital profiles – key facilities are profiled based upon their location, clinical services, track record of quality service, medical staff, equipment, accessibility for international patients and recommendations from HTH’s network of 90+ Regional Physician Advisors.
- Health risks & vaccination recommendations
- Pharmacy Information – reliability, typical hours, etc
Local Health System information
Currency Converter & Local time
U.S. & Foreign Embassy contact details
Fire, Police, & Ambulance Emergency Numbers
Telephone Dialing Codes

Health System Profiles provides a unique and succinct evaluation of the health system of many commonly visited countries. Such profiles address critical points of interest, including health insurance and financing issues, hospital and physician access, and quality of care.

Health News and Security Information – Critical health and security news from around the world, including disease outbreak information, travel advisories and public announcements from the U.S. State Department. Available security report topics include:
- Country & city overviews
- Cultural tips
- Security situation(s), including hijacking & kidnapping risks
- Crime, including terrorism & street crime(s)
- Political Stability, including demonstration(s)
- Police and Fire Safety
- Airport, Airlines & Hotels and Ground Transportation Information
- Communications

Translation Guides – Annually updated, interactive tools that allow you to:
- **Drug Translation Guide** – select the brand names of prescriptions and over-the-counter medications you may use in your home country to determine their local generic equivalent name and whether they are available in your host country. The Drug Translation Guide, which supports country-specific brand/generic drug name(s) and preparation(s) in 21-plus frequently visited countries, can also be used to identify the name(s) of the local manufacturer(s)/distributor(s) of such medications, as well as the locally used generic or brand name(s) and formulations for the product.

- **Medical Terms and Phrases** – get translations of commonly used medical terms and phrases from your native language into the language of the country where you are traveling or living. The Medical Terms and Phrases tool contains translations for more than 600 commonly used technical and layperson medical terms in, including but not limited to, English, French, German, Spanish, Portuguese, and Italian. Additionally, Chinese, Japanese, and Russian are available in PDF format.

The Medical Terms translation tool provides assistance in translating names of diseases and medical conditions, body parts, medical equipment, diagnostic tests and procedures.

The Medical Phrases translation tool provides assistance in helping patients to express their symptoms, needs and questions to hospital staff or pharmacy personnel who may not possess the same degree of English fluency as the physicians.

News and Features
- **Healthy Travel/Life Abroad Feature Articles** – Feature length articles written for expatriates and business travelers by HTH Worldwide staff and medical advisors. Sample topics include managing jet lag, avoiding traveler’s diarrhea, and traveling safely with chronic illnesses such as diabetes. The Travel Health Center articles fit into four general categories: “Expatriate Travel Health”, “Business Travel Health”, “General Travel Health”, and “Special Needs Travel Health.”

Customer Support Services 24 hours a day
If you have any questions about the AI Member website or if you require assistance using any of the tools, please call the AI Member Service Center at the number shown on your Identification Card, 24 hours a day, 7 days a week.
Toll free calling is available in much of the world. Please consult the AT&T Wallet Card included in your Welcome Kit or go to https://www.business.att.com/bt/dial_guide.jsp to find the access numbers for your country.

Note: Neither HTH Worldwide nor Aetna Bermuda is a healthcare provider and neither shall be responsible for the availability, quantity, quality or result of medical treatment you or your eligible dependents may receive or for your failure to obtain medical treatment.
International Employee Assistance Program

Aetna International ® (AI) is providing you and your eligible dependents with an International Employee Assistance Program (IEAP). This program offers a full spectrum of behavioral health and work/life services designed to promote overall wellness and help make life more manageable.

There are many aspects of your life. Sometimes trying to juggle them all—work, family, parents, and life—can be challenging. It can be frustrating when you don't know where to go for help, support, or just a listening ear. The Aetna IEAP has services that can help. The Aetna IEAP is designed for anyone who could use a little help in managing demanding everyday situations. You can think of it as your “life management resource.”

Program Overview
IEAP provides you and your eligible dependents with 24-hour toll-free* access to confidential behavioral health services and resources. Your IEAP is available at no cost to you. IEAP services include but are not limited to:

- Up to 5 counseling sessions per issue per year;
- Web-based health and wellness content and self-assessment tools;
- Crisis Management; and
- Consultation for supervisors managing issues in the workplace.

Focus of IEAP for the International Employee:
IEAP addresses the issues you and your eligible dependents may face when located internationally such as:

- Difficulties with cultural adjustment and feelings of isolation;
- Marital and family relationship stress;
- Child care and behavioral concerns;
- Social adaptation needs;
- Alcohol/Substance Abuse;
- Balancing work and home life; and
- Depression.

Multi-lingual Requirements
IEAP staff has multilingual capability to assist multilingual callers. When necessary, access to language translation services is also available.

How You and Your Eligible Dependents Can Access the International Employee Assistance Program and Related Information:

You will receive an IEAP insert in your member kit. The insert contains an overview of the IEAP services, the toll-free* telephone number and web site address.

*Toll-free calling is available in much of the world. Collect calls are accepted if you or your eligible dependents have no access to toll-free calling. See the IEAP insert or your Employer for details.

NOTE: Aetna does not render health care services and/or treatments and, therefore, cannot guarantee any results or outcomes. All participating providers are independent contractors and are neither agents nor employees of Aetna. The availability of any provider cannot be guaranteed and the provider network composition is subject to change.
INFORMED HEALTH® Line

A nurse-facilitated health information service designed to help you become a better health care consumer

Arrangements have been made with Informed Health, Inc., an Aetna Life Insurance Company subsidiary company that offers an information service to assist people like you in becoming better consumers of health care. The service, Informed Health Line (IHL), provides you and your eligible dependents with toll-free*, 24-hour access to credible health information. You can either:

(Alternative 1:) Speak to an experienced, U.S.-based, registered nurses who can:

- Answer questions about health concerns
- Provide current, easy to understand information on a wide-range of health issues such as:
  - common prevention strategies
  - chronic conditions; and
  - complex medical situations
- Discuss options for seeking medical attention
- Help you and your eligible dependents prepare for appointments with your providers

To assist multi-lingual callers, registered nurses have access to AT&T’s language translation service.

(NOTE: Informed Health nurses cannot diagnose, prescribe, or give medical advice.)

(Alternative 2:) Access an audio health library from any touch-tone phone, 24 hours-a-day. The audio health library, which is available in either English or Spanish, offers you and your eligible dependents increased flexibility by allowing you to choose how you access the health information you need. You can decide to speak to a nurse right away or go directly to the audio health library which contains information on thousands of health topics including common conditions and diseases, gender and age-specific health issues, mental health/substance abuse, weight loss and much more. Information for the particular conditions specified will be made available through the Audio Health Library by entering a four-digit code that corresponds to the condition.

Advantages of IHL:

Informed Health Line offers useful information to educate you and your eligible dependents about a variety of health topics; increase your awareness and understanding of important health issues; and help you to more effectively communicate with your providers.

For you and your eligible dependents: The IHL service offers 24-hour access to health information provided by qualified U.S.-based professionals, as well as supplemental written materials. These tools may help empower you to actively participate in your care and may help improve the effectiveness and efficiency of that care. For example, information provided by Informed Health Line nurses may help you identify problems to your physicians that might otherwise be ignored, thus leading to early treatment of potentially serious and costly health conditions.

How You Can Take Advantage of Informed Health Line Services:

You may receive:

- a convenient AT&T wallet card that provides the toll-free* telephone number through which health information services can be accessed;
- a welcome flyer that provides an overview of the services available through Informed Health;
- information from on-line medical databases and journals (mailed to you upon request); and
- access to round-the-clock, toll-free*, confidential health care information Both the Audio Health Library and the Service’s U.S.-based registered nurses are available 24 hours a day, 7 days a week.

You or your eligible dependents can call the toll-free* number that has been provided.
NOTE: Neither Aetna International ® nor Informed Health is a healthcare provider and neither shall be responsible for the availability, quantity, quality, or result of any medical treatment a member may receive, or for a member’s failure to pursue or obtain medical treatment.

* Toll-free calling is available in much of the world. Refer to your Plan’s AT&T Wallet Card for available locations.
Schedule of Benefits
(GR-9N-S-01-001-01 DE)

Employer: Adobe Systems Incorporated

Control Number: 447926

Issue Date: February 1, 2016
Effective Date: January 1, 2016
Schedule: 3A
Cert Base: 3

For: Comprehensive Dental Plan

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

Comprehensive Dental Plan (GR-9N200501)

Schedule of Comprehensive Dental Benefits

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The Calendar Year deductible applies to all covered expenses except Type A Expenses and Orthodontic Expenses.

Plan Coinsurance:
Please refer to the listing of covered expenses and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

Type A Expenses 100%
Type B Expenses 80%
Type C Expenses 50%
Orthodontic Treatment 50%

Calendar Year Maximum Benefit
Calendar Year Maximum Benefit $1,500

The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

Orthodontic Lifetime Maximum Benefit
Orthodontic Lifetime Maximum Benefit $1,500

The most the plan will pay for covered expenses incurred by any one covered person is called the orthodontic lifetime maximum benefit.
Expense Provisions (GR-9N-S-09-05-01 DE)

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.

The insurance described in this Schedule of Benefits will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Deductible Provisions (GR-9N-S-09-05-01 DE)

Calendar Year Deductible
This is an amount of covered expenses incurred each Calendar Year for which no benefits will be paid. The Calendar Year deductible applies separately to you and each of your covered dependents. After covered expenses reach the Calendar Year deductible, the plan will begin to pay benefits for covered expenses for the rest of the Calendar Year.

Family Deductible Limit
When you incur covered expenses that apply toward the Calendar Year deductibles for you and each of your covered dependents these expenses will also count toward the Calendar Year family deductible limit. Your family deductible limit will be considered to be met for the rest of the Calendar Year once the combined covered expenses reach the family deductible limit in a Calendar Year.

Coinsurance Provisions (GR-9N S-09-020 01)

Coinsurance
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 Coinsurance”. 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 coinsurance percentage may vary by the type of expense. Refer to your Schedule of Benefits for coinsurance amounts for each covered benefit.

Maximum Benefit Provisions (GR-9N S-09-025 01)

Calendar Year Maximum Benefit
The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit will not deny benefits for certain covered expenses in any one Calendar Year.

Lifetime Maximum Benefit
The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

The Lifetime Maximum Benefit will not deny benefits for certain covered expenses.

General (GR-9N-28-01-01-DE)

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-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.
BENEFIT PLAN

Prepared Exclusively For
Adobe Systems Incorporated

Basic Vision Plan

Aetna Life Insurance Company
Booklet-Certificate

What Your Plan Covers and How Benefits are Paid

This Booklet-Certificate is part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder
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*Defines the Terms Shown in Bold Type in the Text of This Document.
Aetna Life Insurance Company (ALIC) is pleased to provide you with this Booklet-Certificate. Read this Booklet-Certificate carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as Aetna).

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

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

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

Group Policyholder: Adobe Systems Incorporated
Control Number: 447926
Effective Date: January 1, 2016
Issue Date: February 1, 2016
Booklet-Certificate Number: 2

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)
Important Information Regarding Availability of Coverage (GR-9N 02 005 02)

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

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

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

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

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

Benefits may be modified during the term of this plan as specifically provided under the terms of the Group Insurance Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the Group Insurance Policy or in this Booklet-Certificate beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.
Coverage for You and Your Dependents (GR-9N-02-005-01 DE)

Health Expense Coverage (GR-9N-02-020-01 DE)

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

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

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

Treatment Outcomes of Covered Services (GR-9N-02-020-01 DE)

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

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.

Determining if You Are in an Eligible Class (GR-9N:29:005:02)
You are in an eligible class if:

- You are a regular full-time employee of Adobe Systems Incorporated participating in this plan working a minimum of 25 hours per week and you elected coverage under the plan.

Determining When You Become Eligible (GR-9N:29:005:02)
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 (GR-9N:29:010:01)
Your dependents can be covered under your plan. You may enroll the following dependents:

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

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.
Coverage for Domestic Partner
A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past six months.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she has cohabitated and resided with you in the same residence for the past six months and intends to cohabitate and reside with you indefinitely.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
  - Common ownership of a motor vehicle;
  - Driver’s license listing a common address;
  - Proof of joint bank accounts or credit accounts;
  - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
  - Assignment of a durable property power of attorney or health care power of attorney.

Coverage for Dependent Children
To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child 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 this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.
How and When to Enroll (GR-9N 29.015.02)

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 31 days of your eligibility date.

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.

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

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 the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period.

When Your Coverage Begins (GR-9N 29.025.02)

Your Effective Date of Coverage
Your coverage takes effect on:

- The date you are eligible for coverage.

Your Dependent’s Effective Date of Coverage
Your dependent’s coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan by then.

Note: New dependents need to be reported to Aetna within 31 days because they may affect your contributions.
Requirements For Coverage (GR-9N-09-005-01 DE)

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

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

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

3. The service or supply must be medically necessary. To meet this requirement, the medical services or 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:
   - In accordance with generally accepted standards of medical practice;
   - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
   - Not primarily for the convenience of the patient, physician or other health care provider;
   - 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 or 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.
Your Aetna Vision Expense Plan (GR-9N-22-005-02 DE)

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

- Definitions you need to know;
- How to access services, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What 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.

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

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

Getting Started: Common Terms (GR-9N-22-010-01)

You will find terms used throughout this Booklet-Certificate. They are described within the sections that follow, and you can also refer to the Glossary at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the Glossary.

About the Basic Vision Expense Plan (GR-9N-22-015-01)

Using the Plan
The Basic Vision Expense plan will pay for covered expenses, up to the maximums shown in the Schedule of Benefits.

- You can directly access physicians and other vision care providers of your choice for covered vision services and supplies under the plan.
- You may have to pay the provider or facility full charges and submit a claim to receive reimbursement from the plan. You will be responsible for completing and submitting claim forms for reimbursement of covered expenses you paid directly to the provider. Aetna will reimburse you for a covered expense up to the recognized charge, less any cost sharing required by you.
- You will receive notification of what the plan has paid toward your covered expenses. It will indicate any amounts you owe towards your deductible, coinsurance or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.
Cost Sharing

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

- You must satisfy any deductibles before the plan begins to pay benefits.
- After you satisfy any applicable deductible, you will be responsible for any applicable coinsurance for covered expenses that you incur.
- Your coinsurance will be based on the recognized charge. If the health care provider you select charges more than the recognized charge, you will be responsible for any expenses above the recognized charge.
- 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.

Basic Vision Expense Plan (GR.9N-24-055-02 DE) (GR.9N-24-010-02 DE)

What the Plan Covers
This plan covers charges for certain vision care supplies described below. The plan limits coverage to a maximum benefit amount per benefit period. Refer to your Schedule of Benefits to determine the maximum benefits that apply to your plan, if any. You are responsible for any cost-sharing amounts, and any expenses you incur in excess of the benefit maximum, listed in the Schedule of Benefits.

Vision Supplies
This plan covers charges for lenses and frames, or prescription contact lenses when prescribed by a legally qualified ophthalmologist or optometrist, up to the Vision Supply Maximum, per benefit period listed in your Schedule of Benefits.

Limitations
All covered expenses are subject to the vision expense exclusions in this Booklet-Certificate and are subject to the deductible(s), copayments or coinsurance listed in the Schedule of Benefits, if any.

Coverage is subject to the exclusions listed in the Vision Care Exclusions section of this Booklet-Certificate.

Benefits for Vision Care Supplies After Your Coverage Terminates
If your coverage under the plan terminates while you are not totally disabled, the plan will cover expenses you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete eye exam was performed in the 30 days before your coverage ended, and the exam included refraction; and
- The exam resulted in lenses being prescribed for the first time, or new lenses ordered due to a change in prescription.

Coverage is subject to the benefit maximums described above and in your Schedule of Benefits.

Vision Plan Exclusions (GR.9N-28-030-02 DE)
Not every vision care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician. The plan covers only those services and supplies that are medically necessary and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What the Plan Covers section or by amendment attached to this Booklet-certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These vision exclusions are in addition to the exclusions listed under your medical coverage.

Any charges in excess of the benefit, dollar, or supply limits stated in this Booklet-Certificate.
Any exams given during your stay in a hospital or other facility for medical care.

An eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses.

Drugs or medicines.

Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.

For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.

For an eye exam which:

- Is required by an employer as a condition of employment; or
- An employer is required to provide under a labor agreement; or
- Is required by any law of a government.

**Prescription** or over-the-counter drugs or medicines.

Special vision procedures, such as orthoptics, vision therapy or vision training.

Vision service or supply which does not meet professionally accepted standards.

Anti-reflective coatings.

Tinting of eyeglass lenses.

Duplicate or spare eyeglasses or lenses or frames for them.

Lenses and frames furnished or ordered because of an eye exam that was done before the date the person becomes covered.

Replacement of lost, stolen or broken prescription lenses or frames.

Special supplies such as nonprescription sunglasses and subnormal vision aids.

Vision services that are covered in whole or in part:

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder; or
- Under any workers’ compensation law or any other law of like purpose.

**When Coverage Ends** (GR-9N-30-005-05 DE)

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

**When Coverage Ends for Employees**

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
You do not make any required contributions;
You become covered under another plan offered by your employer;
You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, Aetna may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  – If you are not actively at work due to illness or injury, your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.
  – If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

It is your employer’s responsibility to let Aetna know when your employment ends. The limits above may be extended only if Aetna and your employer agree, in writing, to extend them.

When Coverage Ends for Dependents
Coverage for your dependents will end if:

- You are no longer eligible for dependents’ coverage;
- You do not make your contribution for the cost of dependents’ coverage;
- Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan’s definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

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

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See Continuation of Coverage for more information.

Continuation of Coverage

Continuing Health Care Benefits

Continuing Coverage for Dependent Students on Medical Leave of Absence
If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious illness or injury, such child’s coverage under this plan may continue.
Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. Aetna may require a written certification from the treating physician which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or change in full-time student status) is medically necessary.

**Important Note**

If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

**Handicapped Dependent Children** *(GR-9N-31-015-01)*

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 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

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

Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.
Extension of Benefits  (GR-9N 31-020 01)

Coverage for Health Benefits
If your health benefits end while you are totally disabled, your health expenses will be extended as described below, but, with respect to medical benefits, only as to expenses incurred in connection with the injury or illness that caused the total disability. To find out why and when your coverage may end, please refer to When Coverage Ends.

“Totally disabled” means that because of an injury or illness:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage  (GR-9N 31-020 01)

Vision: Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

When Extended Health Coverage Ends
Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)
COBRA Continuation of Coverage

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

Continuing Coverage through COBRA

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer’s notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

Who Qualifies for COBRA

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

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

<table>
<thead>
<tr>
<th>Qualifying Event Causing Loss of Health Coverage</th>
<th>Covered Persons Eligible to Elect Continuation</th>
<th>Maximum Continuation Periods</th>
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<tr>
<td>Your active employment ends for reasons other than gross misconduct</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
<tr>
<td>Your working hours are reduced</td>
<td>You and your dependents</td>
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</tr>
<tr>
<td>You divorce or legally separate and are no longer responsible for dependent coverage</td>
<td>Your dependents</td>
<td>36 months</td>
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<tr>
<td>You become entitled to benefits under Medicare</td>
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<td>36 months</td>
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<td>Your covered dependent children no longer qualify as dependents under the plan</td>
<td>Your dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>You die</td>
<td>Your dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>You are a retiree eligible for health coverage and your former employer files for bankruptcy</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
</tbody>
</table>
Disability May Increase Maximum Continuation to 29 Months  
**If You or Your Covered Dependents Are Disabled.**

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

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

**If There Are Multiple Qualifying Events.**

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

**Determining Your Premium Payments for Continuation Coverage**

Your premium payments are regulated by law, based on the following:

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

**When You Acquire a Dependent During a Continuation Period**

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

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

**Important Note**

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

**When Your COBRA Continuation Coverage Ends**

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

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

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 also include the right and opportunity to make an autopsy in the case of death where it is not prohibited by law. This will be done at no cost to you.

Legal Action

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

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

Confidentiality

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

Additional Provisions

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- 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 policy. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or Aetna.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.
Assignments (GR-9N 32-005 02 DE)

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

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

Misstatements (GR-9N-32-005-03)

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

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

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

Incontestability

As to Accident and Health Benefits:

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

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

Recovery of Overpayments (GR-9N-32-015-01 DE)

Health Coverage

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

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

Such right does not affect any other right of recovery Aetna may have with respect to such overpayment.
Reporting of Claims (GR.9N-32-020-01 DE) (GR.9N-32-015-01 DE)

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

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

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. 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 (GR.9N-32-025-02)

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.

Any unpaid balance will be paid within 30 days of receipt by Aetna of the due written proof.

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

Records of Expenses (GR.9N-32-030-02)

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

Very important are:

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

Contacting Aetna

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

Aetna Life Insurance Company
Attention: Aetna International
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.aetnainternational.com.
Effect of Prior Coverage - Transferred Business (GR.9N 32.040 02 DE)

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

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

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

coverage under this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided under the section, Continuing Coverage for Dependent Students on Medical Leave of Absence.

Discount Programs (GR.9N 32.045 01)

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 healthy 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 (GR.9N 32.045 01)

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.
Appeals Procedure (GR.9N-32.050-01 DE)

Definitions

Adverse Benefit Determination (Decision): 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.
- 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.
- A decision that the service or supply is not medically necessary.

An adverse benefit determination also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

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

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

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

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

External Review: A review of an adverse benefit determination or a final adverse benefit determination by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner and made up of physicians or other appropriate health care providers. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An adverse benefit determination that has been upheld by Aetna at the exhaustion of the appeals process.

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:

- Seriously jeopardize your life or health;
- 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.

Full and Fair Review of Claim Determinations and Appeals

As to medical and prescription drug claims and appeals only, Aetna will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the final adverse benefit determination is required to be provided so that you may respond prior to that date.
Prior to issuing a final adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of final adverse determination is required.

Claim Determinations
Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and prescription drug claims only, if Aetna makes an adverse benefit determination, written notice will be provided to you, or in the case of a concurrent care claim, to your provider.

Urgent Care Claims
Aetna will notify you of an urgent care claim decision as soon as possible, but not later than 72 hours after the claim is made.

If more information is needed to make an urgent claim decision, Aetna will notify the claimant within 72 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 to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the physician to provide Aetna with the information.

Pre-Service Claims
Aetna will notify you of a pre-service claim decision as soon as possible, but not later than 15 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar day claim decision 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 day period. If this extension is needed because Aetna needs more information to make a claim decision, 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 notify you of a post-service claim decision as soon as possible, but not later than 30 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim decision 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 more information to make a claim decision, 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 notify you of a claim decision for urgent care as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 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 notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal.

If you file an appeal, coverage under the plan will continue for the previously approved course of treatment until a final appeal decision is rendered. During this continuation period, you are responsible for any copayments, coinsurance; and deductibles; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under appeal. If Aetna's initial claim decision is upheld in the final appeal decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.
**Complaints**

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write to Member Services. The complaint 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 more 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 depending upon the type of coverage provided under the Plan. A final adverse benefit determination notice will also provide an option to request an External Review (if available).

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an adverse benefit determination to request your Level One Appeal. Your appeal may be submitted orally or in writing and must include:

- Your name.
- The employer's name.
- A copy of Aetna's notice of an adverse benefit determination.
- Your reasons for making the appeal.
- Any other information you would like to have considered.

Send your written appeal to Member Services at the address shown on your ID Card, or call in your appeal to Member Services using the telephone number shown on your ID card.

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

You may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.

**Level One Appeal**

A review of a Level One Appeal of an adverse benefit determination shall be provided by Aetna personnel. They shall not have been 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 22 calendar days of receipt of the request for an appeal.

**Level Two Health Appeal**

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

Review of 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. They shall not have been 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 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 a Level Two Appeal.

Post-Service Claims
Aetna shall issue a decision within 23 calendar days of receipt of the request for a Level Two Appeal.

Aetna may extend the Utilization Management Appeal review for up to an additional thirty (30) calendar days for reasonable cause by submitting a written explanation for the delay to the Delaware Department of Insurance within the original thirty (30) calendar review period. In no event, may Aetna extend the review period for an Urgent Care Claim or Concurrent Care Claim Extension.

In the event Aetna fails to comply with any of the above Level 1 or Level 2 Utilization Management Appeal timeframes, or in the event Aetna waives its rights to review an Utilization Management Appeal, you shall be relieved of your obligation to complete the two levels of Utilization Management Appeal, and at your option, may proceed directly to the External Utilization Management Appeal process.

You and/or an authorized representative may attend the Level Two Appeal hearing and question the representative of Aetna and/or any other witnesses, and present their case. Aetna shall acknowledge receipt of all Level 2 Utilization Management Appeals in writing to you. This acknowledgement shall include the place, date and time of the Level 2 Appeal hearing and provide you with at least fifteen (15) calendar days notice of the Level 2 Appeal hearing. You may request a change in the hearing schedule to facilitate attendance. The hearing will be informal. Your physician or other experts may testify. Aetna also has the right to present witnesses.

Exhaustion of Process
You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- Contact the Delaware Department of Insurance to request an investigation of a complaint or appeal; or
- File a complaint or appeal with the Delaware Department of Insurance; or
- Establish any:
  - Litigation;
  - Arbitration; or
  - Administrative proceeding;
regarding an alleged breach of the policy terms by Aetna or any matter within the scope of the Appeals Procedure.

Under certain circumstances, you may seek simultaneous review through the internal Appeals Procedure and External Review processes—these include Urgent Care Claims and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:
If Aetna does not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the appeal requirements and may proceed with External Review or any of the actions mentioned above. There are limits, though, on what sends a claim or appeal straight to an External Review.

Your claim or internal appeal will not go straight to External Review if:

- a rule violation was minor and isn’t likely to influence a decision or harm you;
- it was for a good cause or was beyond Aetna’s control; and
- it was part of an ongoing, good faith exchange between you and Aetna.
Independent Health Care Appeals Program (GR-9N-32-031-01 DE)
(External Utilization Management Appeal Process)

1. Upon receipt of a Level 2 Utilization Management Appeal adverse benefit determination, if you are dissatisfied with the results, you may pursue a Utilization Management Appeal before an Independent Utilization Review Organization (IURO).

2. You must file the request for an Utilization Management Appeal with Aetna within four (4) months of receipt of the Adverse benefit determination from the Utilization Management Appeal process. Upon receipt of your request for an external review, Aetna shall fax or send an electronic copy of the Petition for External Review form within three (3) business days to the Delaware Department of Insurance and then follow with a hard copy of the request to the Department by mail.

3. Once the request for an external review is received by the Department, the Department will assign an approved IURO to conduct the external review and notify Aetna.

4. Within 5 calendar days of the assignment, the assigned IURO will notify you in writing by certified or registered mail (requesting delivery confirmation by the United States Postal Service), that the Utilization Management Appeal was accepted for external review. This notice will include a provision stating that you, within seven (7) calendar days of this written notice, may submit additional information and supporting document that you would like the IURO to consider when conducting the external review. Upon receipt of any information submitted by you, the assigned IURO shall forward the information to Aetna with in two (2) business days.

5. Within seven (7) business days after Aetna receives notice of the assigned IURO, Aetna shall provide the assigned IURO the documents and any information considered in making the Utilization Management Appeal adverse benefit determination. If Aetna fails to submit this documentation and information or fails to participate within the time specified, the assigned IURO may terminate the external review and make a decision, with the approval of the Department, to reverse the Utilization Management Appeal adverse benefit determination.

6. The external review may be terminated if Aetna decides to reverse its adverse benefit determination and provide coverage or payment for the health care service that is the subject of the Utilization Management Appeal. Immediately upon making this decision, Aetna will notify you, the assigned IURO and the Department in writing of its decision. Upon receipt of this written notice from Aetna, the assigned IURO shall terminate the external review.

7. Within forty-five (45) calendar days after the receipt of the request for external review, the assigned IURO will provide written notice to you (by certified or registered mail requesting delivery confirmation by the United States Postal Service), Aetna and the Department of its decision to uphold or reverse the Aetna adverse benefit determination.

8. The decision of the IURO is binding upon Aetna.

Expeditied External Utilization Management Appeal Process

1. You may request an expedited external review with Aetna at the time you receive a final Level 2 adverse benefit determination from Aetna if you suffer from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition.

2. At the time Aetna receives a request for an expedited external review, Aetna shall immediately fax or send an electronic copy of the Petition for External Review form to the Department and mail a hard copy of the form to the Department.

3. If the Department determines that the review meets the criteria for expedited review, the Department will assign an approved IURO to conduct the external review and notify Aetna. Upon receipt of the notification, Aetna will expeditiously provide or transmit all necessary documents and information considered in making the final adverse benefit determination.
4. Within seventy-two (72) after the date of the receipt of the request for an expedited external review, the IURO shall:

   a) Make a decision to uphold or reverse the final adverse benefit determination; and
   b) Immediately notify you, Aetna and the Department of the decision.
   c) Within two (2) calendar days of that notification, the IURO shall provide written confirmation of the decision to you, Aetna, and the Department.

5. The decision of the IURO is binding upon Aetna.
Glossary

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

A (GR-9N 34-005 05)

**Aetna**

*Aetna* Life Insurance Company, an affiliate, or a third party vendor under contract with *Aetna*.

C (GR-9N 34-015 02)

**Coinsurance**

Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as "plan coinsurance" and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on coinsurance amounts.

**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*.

**Covered Expenses**

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

D (GR-9N 34-020 01)

**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*.

H (GR-9N 34-040 02)

**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.
Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

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.

Medically Necessary or Medical Necessity
These are 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 give to a patient for the purpose of:
- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an illness;
  - an injury;
  - a disease; or
  - its symptoms.

The provision of the service, supply or prescription drug must be:

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 mostly for the convenience of the patient, physician, other health care or dental provider; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same 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. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with physician or dental specialty society recommendations. They must be consistent with the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

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.

**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.

**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.

R (GR-9N-34-090-01 DE)

Recognized Charge
Only that part of a charge which is recognized is a covered benefit. The recognized charge for a service or supply is the amount billed by the provider.

S (GR-9N 34-95-10 DE)

Stay
A full-time inpatient confinement for which a room and board charge is made.
Confidentiality Notice
Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetnainternational.com.
Additional Information Provided by
Adobe Systems Incorporated

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

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

Name of Plan:
Refer to your Plan Administrator for this information

Employer Identification Number:
Refer to your Plan Administrator for this information

Plan Number:
Refer to your Plan Administrator for this information

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Adobe Systems Incorporated
Attention: Susan Burke - Mgr, Vendor Partner Office
345 Park Avenue W07-431
San Jose, CA 95110
Telephone Number: (408) 536-4433

Agent For Service of Legal Process:
Adobe Systems Incorporated
345 Park Avenue W07-431
San Jose, CA 95110

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.
ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

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

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

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

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

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

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

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

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.
If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator.

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

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

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 leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

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

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

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

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

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

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

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

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

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.
On-line Global Health and Travel Information from HTH Worldwide

Through an arrangement with HTH Worldwide (known as “HTH”), Aetna International ® (AI) can now offer you and your eligible dependents access to useful information specifically designed to help global employees and their families research and pursue quality health care virtually anywhere in the world. HTH is a leading provider of web-based health and travel information and services that are specifically tailored to help address the global needs of individuals living, working and traveling outside their home country.

By visiting the AI Member website http://www.aetnainternational.com you and your eligible dependents can access a suite of self-service, web based tools that may help you to be more self-reliant and better prepared for health related issues you may encounter during your international assignment.

Through AI’s online Member Service Center, you will have access to the important resources described in the following section(s).

What Types of Resources Are Available Through HTH?

Provider Community

International Provider Community – A community of over 2,500 English-speaking, pre-identified physicians, dentists, psychologists and other allied health professionals who are located in over 120 countries and who represent 24 medical specialties recognized by the American Board of Medical Specialties.

Providers are selected based on their professional qualifications, clinical experience, hospital affiliations, language skills, continuing medical education, peer recommendations, and positive experience with expatriate patients. Hand-selected providers must also have one of the following: verified current American Board of Medical Specialties certification; verified current Royal Medical or Surgical College membership (from the United Kingdom, Ireland, Canada, Australia, or New Zealand); and/or recommendation by HTH Regional Physician Advisors (RPA), HTH Medical Staff, and/or HTH Recruitment Partner.

In addition to professional qualification information, provider profiles also include ancillary details, which are verified 6 times annually, such as:

- Practice address and contact details
- Email address
- Language(s)
- Special Services (house calls, ambulance, onsite lab)
- Hospital Affiliations

Interactive/Online Tools

Provider search tool – This utility allows you to conduct a personalized on-line search of HTH’s International Provider Community to identify and research physicians and other providers that meet your geographic and medical specialty criteria. A convenient link is also provided to Aetna’s DocFind search engine, which provides information about the broad network of Aetna providers across the United States.

Health and Security Information

CityHealth Profiles® - Information on the healthcare services in the world’s most frequent destinations for international assignees and business travelers. Valuable information that includes, but is not limited to the following, is presented at both a city and country level for more than 200 destinations outside of the United States:

- Notable hospital profiles – key facilities are profiled based upon their location, clinical services, track record of quality service, medical staff, equipment, accessibility for international patients and recommendations from HTH’s network of 90+ Regional Physician Advisors.
- Health risks & vaccination recommendations
- Pharmacy Information – reliability, typical hours, etc
• Local Health System information
• Currency Converter & Local time
• U.S. & Foreign Embassy contact details
• Fire, Police, & Ambulance Emergency Numbers
• Telephone Dialing Codes

**Health System Profiles** provides a unique and succinct evaluation of the health system of many commonly visited countries. Such profiles address critical points of interest, including health insurance and financing issues, hospital and physician access, and quality of care.

**Health News and Security Information** – Critical health and security news from around the world, including disease outbreak information, travel advisories and public announcements from the U.S. State Department. Available security report topics include:
• Country & city overviews
• Cultural tips
• Security situation(s), including hijacking & kidnapping risks
• Crime, including terrorism & street crime(s)
• Political Stability, including demonstration(s)
• Police and Fire Safety
• Airport, Airlines & Hotels and Ground Transportation Information
• Communications

**Translation Guides** – Annually updated, interactive tools that allow you to:
• **Drug Translation Guide** – select the brand names of prescriptions and over-the-counter medications you may use in your home country to determine their local generic equivalent name and whether they are available in your host country. The Drug Translation Guide, which supports country-specific brand/generic drug name(s) and preparation(s) in 21-plus frequently visited countries, can also be used to identify the name(s) of the local manufacturer(s)/distributor(s) of such medications, as well as the locally used generic or brand name(s) and formulations for the product.

• **Medical Terms and Phrases** – get translations of commonly used medical terms and phrases from your native language into the language of the country where you are traveling or living. The Medical Terms and Phrases tool contains translations for more than 600 commonly used technical and layperson medical terms in, including but not limited to, English, French, German, Spanish, Portuguese, and Italian. Additionally, Chinese, Japanese, and Russian are available in PDF format.

The Medical Terms translation tool provides assistance in translating names of diseases and medical conditions, body parts, medical equipment, diagnostic tests and procedures.

The Medical Phrases translation tool provides assistance in helping patients to express their symptoms, needs and questions to hospital staff or pharmacy personnel who may not possess the same degree of English fluency as the physicians.

**News and Features**
• **Healthy Travel/Life Abroad Feature Articles** – Feature length articles written for expatriates and business travelers by HTH Worldwide staff and medical advisors. Sample topics include managing jet lag, avoiding traveler’s diarrhea, and traveling safely with chronic illnesses such as diabetes. The Travel Health Center articles fit into four general categories: “Expatriate Travel Health”, “Business Travel Health”, “General Travel Health”, and “Special Needs Travel Health.”
Customer Support Services 24 hours a day
If you have any questions about the AI Member website or if you require assistance using any of the tools, please call the AI Member Service Center at the number shown on your Identification Card, 24 hours a day, 7 days a week.

Toll free calling is available in much of the world. Please consult the AT&T Wallet Card included in your Welcome Kit or go to https://www.business.att.com/bt/dial_guide.jsp to find the access numbers for your country.

Note: Neither HTH Worldwide nor Aetna Bermuda is a healthcare provider and neither shall be responsible for the availability, quantity, quality or result of medical treatment you or your eligible dependents may receive or for your failure to obtain medical treatment.
International Employee Assistance Program

Aetna International ® (AI) is providing you and your eligible dependents with an International Employee Assistance Program (IEAP). This program offers a full spectrum of behavioral health and work/life services designed to promote overall wellness and help make life more manageable.

There are many aspects of your life. Sometimes trying to juggle them all—work, family, parents, and life—can be challenging. It can be frustrating when you don’t know where to go for help, support, or just a listening ear. The Aetna IEAP has services that can help. The Aetna IEAP is designed for anyone who could use a little help in managing demanding everyday situations. You can think of it as your “life management resource.”

Program Overview
IEAP provides you and your eligible dependents with 24-hour toll-free* access to confidential behavioral health services and resources. Your IEAP is available at no cost to you. IEAP services include but are not limited to:

- Up to 5 counseling sessions per issue per year;
- Web-based health and wellness content and self-assessment tools;
- Crisis Management; and
- Consultation for supervisors managing issues in the workplace.

Focus of IEAP for the International Employee:

IEAP addresses the issues you and your eligible dependents may face when located internationally such as:

- Difficulties with cultural adjustment and feelings of isolation;
- Marital and family relationship stress;
- Child care and behavioral concerns;
- Social adaptation needs;
- Alcohol/Substance Abuse;
- Balancing work and home life; and
- Depression.

Multi-lingual Requirements
IEAP staff has multilingual capability to assist multilingual callers. When necessary, access to language translation services is also available.

How You and Your Eligible Dependents Can Access the International Employee Assistance Program and Related Information:

You will receive an IEAP insert in your member kit. The insert contains an overview of the IEAP services, the toll-free* telephone number and web site address.

*Toll-free calling is available in much of the world. Collect calls are accepted if you or your eligible dependents have no access to toll-free calling. See the IEAP insert or your Employer for details.

NOTE: Aetna does not render health care services and/or treatments and, therefore, cannot guarantee any results or outcomes. All participating providers are independent contractors and are neither agents nor employees of Aetna. The availability of any provider cannot be guaranteed and the provider network composition is subject to change.
INFORMED HEALTH® Line

A nurse-facilitated health information service designed to help you become a better health care consumer

Arrangements have been made with Informed Health, Inc., an Aetna Life Insurance Company subsidiary company that offers an information service to assist people like you in becoming better consumers of health care. The service, Informed Health Line (IHL), provides you and your eligible dependents with toll-free*, 24-hour access to credible health information. You can either:

(Alternative 1:) Speak to an experienced, U.S.-based, registered nurses who can:

- Answer questions about health concerns
- Provide current, easy to understand information on a wide-range of health issues such as:
  - common prevention strategies
  - chronic conditions; and
  - complex medical situations
- Discuss options for seeking medical attention
- Help you and your eligible dependents prepare for appointments with your providers

To assist multi-lingual callers, registered nurses have access to AT&T’s language translation service.

(NOTE: Informed Health nurses cannot diagnose, prescribe, or give medical advice.)

(Alternative 2:) Access an audio health library from any touch-tone phone, 24 hours-a-day. The audio health library, which is available in either English or Spanish, offers you and your eligible dependents increased flexibility by allowing you to choose how you access the health information you need. You can decide to speak to a nurse right away or go directly to the audio health library which contains information on thousands of health topics including common conditions and diseases, gender and age-specific health issues, mental health/ substance abuse, weight loss and much more. Information for the particular conditions specified will be made available through the Audio Health Library by entering a four-digit code that corresponds to the condition.

Advantages of IHL:

Informed Health Line offers useful information to educate you and your eligible dependents about a variety of health topics; increase your awareness and understanding of important health issues; and help you to more effectively communicate with your providers.

For you and your eligible dependents: The IHL service offers 24-hour access to health information provided by qualified U.S.-based professionals, as well as supplemental written materials. These tools may help empower you to actively participate in your care and may help improve the effectiveness and efficiency of that care. For example, information provided by Informed Health Line nurses may help you identify problems to your physicians that might otherwise be ignored, thus leading to early treatment of potentially serious and costly health conditions.

How You Can Take Advantage of Informed Health Line Services:

You may receive:

- a convenient AT&T wallet card that provides the toll-free* telephone number through which health information services can be accessed;
- a welcome flyer that provides an overview of the services available through Informed Health;
- information from on-line medical databases and journals (mailed to you upon request); and
- access to round-the-clock, toll-free*, confidential health care information Both the Audio Health Library and the Service’s U.S.-based registered nurses are available 24 hours a day, 7 days a week.
You or your eligible dependents can call the toll-free* number that has been provided.

NOTE: Neither Aetna International ® nor Informed Health is a healthcare provider and neither shall be responsible for the availability, quantity, quality, or result of any medical treatment a member may receive, or for a member’s failure to pursue or obtain medical treatment.

* Toll-free calling is available in much of the world. Refer to your Plan’s AT&T Wallet Card for available locations.
Schedule of Benefits

Employer: Adobe Systems Incorporated
Control Number: 447926
Issue Date: February 1, 2016
Effective Date: January 1, 2016
Schedule: 2A
Cert Base: 2

For: Basic Vision Plan

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

Basic Vision Expense Coverage (GR-9N-24-005-02 DE)

Vision Supply Maximum - $100 per 24 month period.

Expense Provisions (GR-9N-09-05-01 DE)

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.

The insurance described in this Schedule of Benefits will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

General (GR-9N-28-01-01-DE)

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-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.
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Preface (GR-9N-02-005-01)

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

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

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

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

Group Policyholder: Adobe Systems Incorporated
Control Number: 447926
Effective Date: January 1, 2016
Issue Date: February 1, 2016
Booklet-Certificate Number: 4

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)
Important Information Regarding Availability of Coverage

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

Unless specifically provided in any applicable termination provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for the loss of life or an *accident* incurred before coverage starts under this plan.

This plan will also not pay any benefits for any losses that start after coverage ends.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any losses that start on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal if the loss or *accident* happens on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.
Coverage for You

Life Insurance Coverage
A benefit is payable if you lose your life while coverage is in effect. Please refer to the Life Insurance section for more details about covered losses.
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”, "your" and "yours" means the employee to whom this Booklet-Certificate is issued and whose insurance is in force under the terms of this group insurance policy.

**Who Is Eligible**

Your employer determines the criteria that are used to define the eligible class for coverage under this plan. Such criteria are based solely upon the conditions related to your employment. Aetna will rely upon the representation of the employer as to your eligibility for coverage under this plan and as to any fact concerning such eligibility.

**Employees**

You are eligible for coverage under this plan if you are **actively at work** and:

- You are in an eligible class, as defined below;
- You have completed any probationary period required by the policyholder; and
- You have reached your eligibility date.

**Determining if You Are in an Eligible Class**

You are in an Eligible Class if you are a regular full-time employee of Adobe Systems Incorporated participating in this plan.

In addition, to be in an eligible class you must be scheduled to work on a regular basis at least 25 hours per week during your Employer's work week.

**Eligibility for Life Insurance if Permanently and Totally Disabled**

You may remain eligible for Life Insurance coverage, subject to change or termination as provided elsewhere in the group contract, if your Employer determines that you have become permanently and totally disabled, if the total disability starts:

- while you are insured; and
- on or after the date this subsection applies to you; and
- before you retire; and
- your employer continues premium payments for this coverage.

This eligibility ceases the date your Employer determines that you are no longer permanently and totally disabled.

Report a disease or injury to your Employer as soon as you can. Your Employer will help you determine if you qualify.
Determining When You Become Eligible (GR.9N-29.005-02)
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.

How and When to Enroll (GR.9N 29.015-02)

Enrollment
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.

When Your Coverage Begins (GR.9N-29.025-01)

Your Effective Date of Coverage
Your coverage takes effect on:

- The date you are eligible for coverage.

Active Work Rule: If you happen to be ill or injured and away from work on the date your coverage would take effect, the coverage will not take effect until you return to full-time work for one full day. This rule also applies to an increase in your coverage.
Life insurance is an important component of your financial planning. The Life Insurance Plan pays a benefit to your beneficiary if you die while covered by the plan. Refer to the *Schedule of Life Insurance Benefits* for information about the plan's benefit. This section will help you understand the following:

- Naming a Beneficiary
- Payment of Benefits, and
- How to change coverage amounts

### How the Plan Works

#### Naming Your Beneficiary

A beneficiary is the person you designate to receive life benefits if you should die while you are covered. You may name anyone you wish as your beneficiary. You may name more than one beneficiary. You will need to complete a beneficiary designation form, which you can get from your employer.

If you name more than one primary beneficiary, the life insurance benefits will be paid out equally unless you stipulate otherwise on the form. If you name more than one primary beneficiary and the amount or percentage of the payment to your primary beneficiaries does not equal 100% of your life insurance amount, the difference will be paid equally to your named primary beneficiaries.

You may change your beneficiary choice at any time by completing a new beneficiary designation form. Send the completed form to your employer or to Aetna. The beneficiary change will be effective on the date you sign a new beneficiary designation form.

Prior to your death, you are the only person who can name or change your beneficiary. No other person may change your beneficiary on your behalf, including, but not limited to, any agent under power of attorney, whether durable or non-durable, or other power of appointment.

*Aetna* pays life insurance benefits in accordance with the beneficiary designation it has on record. Any payment made before *Aetna* receives your request for a beneficiary change will be made to your previously designated beneficiary. *Aetna* will be fully discharged of its duties as to any payment made, if the payment is made before *Aetna* receives notification of a change in beneficiary.

#### If Your Beneficiary Dies Before You

If one of your named primary beneficiaries dies before you, his or her share will be payable in equal shares to any other named primary beneficiaries who survive you. If you have named a contingent beneficiary, your contingent beneficiary will only be paid if all primary beneficiaries die before you.

If you have not named a primary or contingent beneficiary, or if the person you have named dies before you, payment will be made as follows to those who survive you:

- Your spouse or domestic partner, if any.
- If there is no spouse or domestic partner, in equal shares to your children.
- If there is no spouse; or domestic partner or you have no children, to your parents, equally or to the survivor.
▪ If there is no spouse; or domestic partner, or you have no children, or parents, in equal shares to your brothers and sisters.
▪ If none of the above survives, to your executors or administrators.

If Your Beneficiary Is a Minor
The method of payment will differ if your beneficiary is:

▪ A minor; or
▪ Legally unable to give a valid release for payment of any Life Insurance benefit, in Aetna’s opinion.

Aetna will issue (as permitted by applicable state law) the life insurance payment to:

▪ The guardian of your beneficiary's estate; or
▪ The custodian of the beneficiary's estate under the Uniforms Transfer to Minors Act; or
▪ An adult caretaker/legal guardian.

Aetna will be fully discharged of its duties as to the extent of the payment made. Aetna is not responsible for how the payment is used.

Exclusions and Limitations

This Plan will not pay a death benefit if you die by suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the effective date of your coverage.

If your death occurs after two years of the effective date of your coverage, but within two years of the date that any increase in coverage becomes effective, no death benefit will be payable for any such increased amount.

In addition, this Plan will not pay a death benefit if:
▪ You die due to war or any act of war, either declared or undeclared, while you were enlisted for active service connected with such war or act of war.
▪ You die due to warlike operations or hostilities, civil commotions or rebellion in which you takes an active part.

Changes to Your Coverage Amounts

The amount of your life insurance benefit depends on a variety of factors, including your earnings, employment status, and employee class. Your benefit level may change as the result of a change in one or more of these factors.

Changes in Benefit Level
If a change in benefit level increases or decreases your insurance coverage, your new coverage amounts will be effective on the date of the change. If you are not actively at work on the date of the change, the increase in any coverage will be postponed until you return to active work for one full day.

You have the right to refuse an increase in life insurance coverage. You must make this request within 31 days of the date the change would have become effective.

Important Reminder
If you later decide to elect the increase (or any future increase) in life insurance, the change will be effective on the date Aetna gives written consent.
Changes in Non-Contributory Coverage
An increase or decrease in the amount of your coverage as the result of a change in your rate of earnings, employment status, employee class, or benefit level will become effective on the date the change occurs as long as you are actively at work. If you are not actively at work on the date of the change, any increase will be postponed until you return to active work for one full day.

A retroactive change in your rate of earnings, status or classification will not change your coverage retroactively. Any resulting change in coverage will be effective on the date Aetna receives notice of the change, or as otherwise agreed upon between Aetna and your employer.

These rules do not apply to reductions in your coverage due to age or retirement. For more information, please refer to When Life Insurance Amounts Are Reduced section.

When Life Insurance Coverage Amounts are Reduced

Age Reduction Rules
Life insurance amounts will be reduced at age 65 then continue to reduce according to the schedule below.

<table>
<thead>
<tr>
<th>If You Are Age:</th>
<th>Your Insurance Amounts Will Be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>65% of your life amount</td>
</tr>
<tr>
<td>70</td>
<td>40% of your life amount</td>
</tr>
<tr>
<td>75</td>
<td>25% of your life amount</td>
</tr>
</tbody>
</table>

Reductions are based on the amount of life insurance coverage amounts in force.

The reduction will take effect on the first day of the calendar month in which you attain the limiting age.

If you become eligible for coverage after you reach age 65, your amount of life insurance will be figured by multiplying:

- The amount of insurance you would have been eligible for prior to age 65; times
- The applicable percentage, based on your current age, as shown in the above schedule.

When You Retire
Life Insurance coverage ends when you retire.

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; or
- Your employment stops for any reason, including job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, Aetna may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not **actively at work** due to illness or injury, your coverage may continue until stopped by your employer, but not beyond 12 months from the start of the absence.
  - If you are not **actively at work** due to temporary lay-off or leave of absence, your coverage may continue until stopped by your employer. Your coverage will not continue beyond the end of the policy month after the policy month in which your absence started. A "policy month" is defined in the group policy on file with your employer.
  - If you are eligible as a permanently and totally disabled employee, your coverage may be deemed to continue for Life Insurance while you remain eligible.

It is your employer’s responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.
General Provisions (GR-9N-32-005-02)

Legal Action

The following information does not apply to Life Insurance.

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 the operation of the plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of *Aetna’s* Notice of Information Practices at www.aetnainternational.com.

Additional Provisions

The following additional provisions apply to your coverage:

- 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 policy*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or *Aetna*.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

Assignments

An assignment is the transfer of your rights under the group policy to a person you name. *Aetna* and your employer must give written consent to the assignment.

To request assignment of your Life Insurance you must complete an assignment form. Forms are available from your employer. Send the completed form to *Aetna* for consent. You may wish to contact legal counsel prior to assigning your life insurance coverage rights. Neither your employer nor *Aetna* guarantees or assumes any obligation concerning the sufficiency or validity of any assignment for purposes of your tax or estate planning.

Claims of Creditors

Life benefit payments are exempt from legal or equitable process for your debts, where permitted by law. The exemption applies to the debts of your beneficiary, too.
Misstatements (GR-9N-32-005-03)

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

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

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

Incontestability (GR-9N-32-005-02)

During the first two years that your insurance is in force, any statement that you have made may be used by Aetna in contesting the validity of that coverage. This also applies to any increase in your coverage for the two years that follow the effective date of that increase, if evidence of good health was required in order for the increase to take effect.

Once coverage (including any increases in coverage) has been continuously in effect for two years, the validity of your insurance (or increase in coverage) under this plan shall not be contested by Aetna unless your statement was in writing on a form signed by you and was fraudulently made in order to obtain that coverage or increase.

Aetna may also contest the validity of your insurance at any time under this plan for non-payment of premiums when due.

Reporting of Claims (GR-9N-32-020-01)

You are required to submit a claim to Aetna in writing. Claim forms may be obtained from Aetna.

Your claim must give proof of the nature and extent of the loss. You must furnish true and correct information as Aetna may reasonably request.

Reporting of Life Insurance Claims
In addition to the above, a claim must be submitted to Aetna in writing.

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

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

Any death benefit for loss of life will be paid in accordance with the beneficiary designation. Payment will be made in one sum.

If your beneficiary is a minor or, in Aetna’s opinion, legally unable to give a valid release for payment of any life insurance benefit or accidental death and personal loss coverage, the benefit will be payable to the guardian of the estate of the minor, or to the custodian under the Uniforms Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law.
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
Attention: Aetna International
151 Farmington Avenue
Hartford, CT 06156

You may visit Aetna’s web site at www.aetnainternational.com.

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.

Your Life Insurance coverage under this plan replaces and supersedes any prior life insurance coverage. It will be in exchange for everything as to the prior life insurance coverage. If you or your beneficiary becomes entitled to claim under the prior life insurance coverage, your Life Insurance coverage under this plan will be canceled. This will be done as of its effective date. Any premiums paid for your Life Insurance coverage under this plan will be returned to your employer.

The beneficiary you named under a prior Aetna life insurance coverage plan will apply to this plan. This can be changed according to the terms of this plan.

Any Age Reduction Rule or Retirement Rule of this policy will apply to you if:

- The Rules do not provide a greater amount of Life Insurance coverage than your amount under the prior coverage; or
- Your Life Insurance coverage had not been reduced under the prior coverage due to age or retirement.

If you do not return to active work within 12 months from the date Life Insurance goes into effect or if the Permanent and Total Disability Extended Benefit does not apply to you, Life Insurance will cease at the end of such 12 month period. This will happen unless otherwise agreed to by the Policyholder and Aetna.

This provision shall terminate if:

- Your Life Insurance terminates; or
- You meet the Active Work Rule.

If you stay insured or again become eligible, this policy shall apply to you as though this provision were not included.
Glossary

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

A (GR-9N-34-005-05)

**Accident** (GR-9N-34-005-02)
This means a sudden external trauma that is; unexpected; and unforeseen; and is an identifiable occurrence or event producing, at the time, objective symptoms of an external bodily injury. The accident must occur while the person is covered under this Policy. The occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an illness or disease of any kind including a reaction to a condition that manifests within the human body or a reaction to a drug or medication regardless of the reason you have consumed the drug or medication.

**Active at Work; Actively at Work; Active Work** (GR-9N-34-005-02)
You will be considered to be active at work, actively at work or performing active work on any of your employer’s scheduled work days if, on that day, you are performing the regular duties of your job on a full time basis for the number of hours you are normally scheduled to work. In addition, you will be considered to be actively at work on the following days:

- any day which is not one of your employer’s scheduled work days if you were actively at work on the preceding scheduled work day; or
- a normal vacation day.

**Aetna**
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

I (GR-9N 34-045 02)

**Illness**
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

**Injury** (GR-9N 34-045 02)
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.

The act or event must be definite as to time and place. An injury is not the direct result of illness.
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.
Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law.

Some of the ways in which personal information is used include claim payment; utilization review and management; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Information Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call 1-866-825-6944 or visit our Internet site at www.aetnainternational.com.
Additional Information Provided by

Adobe Systems Incorporated

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

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

**Name of Plan:**
Refer to your Plan Administrator for this information

**Employer Identification Number:**
Refer to your Plan Administrator for this information

**Plan Number:**
Refer to your Plan Administrator for this information

**Type of Plan:**
Welfare

**Type of Administration:**
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

**Plan Administrator:**
Adobe Systems Incorporated
Attention: Susan Burke - Mgr, Vendor Partner Office
345 Park Avenue W07-431
San Jose, CA 95110
Telephone Number: (408) 536-4433

**Agent For Service of Legal Process:**
Adobe Systems Incorporated
345 Park Avenue W07-431
San Jose, CA 95110

Service of legal process may also be made upon the Plan Administrator

**End of Plan Year:**
December 31

**Source of Contributions:**
Employer

**Procedure for Amending the Plan:**
The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.
ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

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

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

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

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

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

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 subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, your Employer may allow you to continue coverage for which you are covered under the group contract on the day before the approved FMLA leave starts.

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

If 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.

If the group contract provides continuation of coverage (for example, upon termination of employment), you 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 return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

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

<table>
<thead>
<tr>
<th>Employer:</th>
<th>Adobe Systems Incorporated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Number:</td>
<td>447926</td>
</tr>
<tr>
<td>Issue Date:</td>
<td>February 1, 2016</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>January 1, 2016</td>
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<td>Schedule:</td>
<td>4A</td>
</tr>
<tr>
<td>Cert Base:</td>
<td>4</td>
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</tbody>
</table>

For: Life Insurance

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

Schedule of Life Insurance Benefits

<table>
<thead>
<tr>
<th>Classification</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Employees</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

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-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.
Aetna Life Insurance Company
Hartford, Connecticut 06156

Amendment (GR.9N-Appeals 01-01 01)

Policyholder: Adobe Systems Incorporated
Control No.: 447926
Rider: Complaint and Appeals Life Insurance and/or Accidental Death & Personal Loss Coverage Rider

Issue Date: February 1, 2016
Effective Date: January 1, 2016

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

Appeals Procedure
Definitions
Adverse Benefit Determination: A denial; termination of; or failure to provide or make payment (in whole or in part) for a benefit.

Such adverse benefit determination may be based on your eligibility for coverage or your eligibility for benefits.

Appeal: A written request to Aetna to reconsider an adverse benefit determination.

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

Filing Life Claims under the Plan
You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative.

An "authorized representative" means your legal spouse or adult child, or a person you authorize, in writing, to act on your behalf. In addition, the Plan will recognize a court order giving a person authority to submit claims on your behalf.

Claim Determinations – Group Life Coverage (GR.9N-Appeals 01-04 01)
Aetna will make notification of a claim determination as soon as possible but not later than 90 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 90 calendar day claim determination period is required. Such an extension, of not longer than 90 additional calendar days, will be allowed if Aetna notifies you within the first 90 calendar day period. Aetna must notify you, prior to the end of the first 90 calendar day period, of the special circumstances requiring the extension and the date by which a decision can be expected.
Appeals of Adverse Benefit Determinations (GR-9N-Appeals 01-06 01)
You may submit an appeal if Aetna gives notice of an adverse benefit determination.

You have 60 calendar days following the receipt of notice of an adverse benefit determination to request your appeal. Your appeal may be submitted 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.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

Send your appeal to the address shown on the notice of adverse benefit determination.

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

Appeal – Group Life Claims (GR-9N-Appeals 01-09 01)
Aetna shall issue a decision within 60 calendar days of receipt of the request for an appeal. If Aetna determines that due to special circumstances an extension of time for claim processing is required, such an extension, of not longer than 60 additional calendar days, will be allowed if Aetna notifies you within the first 60 calendar day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)
Aetna Life Insurance Company
Hartford, Connecticut 06156

Amendment (GR-9N-CR1)
Policyholder: Butterfield Trust (Bermuda) Limited
Group Policy No.: GP-299080, 299081, 299082, 299083, 299804, 299805, 299806 & 299807
Effective Date: January 1, 2014

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

1. The following section entitled “Obtaining Coverage for Dependents” replaces the same section currently appearing in your Booklet.

Obtaining Coverage for Dependents
Your dependents can be covered under your plan. You may enroll the following dependents:

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

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.

2. The following sub-section has been added entitled “Coverage for Domestic Partner” under the "Obtaining Coverage for Dependents" section in your Booklet.

Coverage for Domestic Partner
To be eligible for coverage, you and your domestic partner will need to complete and sign a Declaration of Domestic Partnership.
3. The following is added to your “When Coverage Ends for Dependents” found under the “When Coverage Ends” section of your Booklet.

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

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

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See Continuation of Coverage for more information.

Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

Domestic Partner Rider  
Rider: 1  
Issue Date: April 14, 2014