Your Health Care Benefits

For questions and assistance with your benefits
or information in this section, contact the
HealthySteps benefits service center at
855-278-7157 (Monday – Friday, 5:00 a.m. – 5:00 p.m. PT).

Lucile Packard Children's Hospital Stanford is a participating employer in the Stanford Health Care Employee Health and Welfare Benefit Plan.

For Non-Represented and SEIU-UHW Represented Employees

Effective January 1, 2017

Stanford HEALTH CARE

Lucile Packard Children's Hospital Stanford

HealthySteps

Your Handbook and Health Booklets

The information provided in this Handbook and in the Health Booklets is intended to provide a Summary Plan Description (SPD) of the benefit plans for Stanford Health Care as the plan sponsor and Lucile Packard Children's Hospital Stanford as a participating employer are referred to as "the hospital" or collectively as "the hospitals." It is your responsibility to read the Handbook and the Health Booklets and to ask questions if you need more information. It is also your responsibility to visit www.healthysteps4u.org to download your plan's Health Booklet. If you do not have access to a computer, please contact the HealthySteps benefits service center to have a paper copy mailed to you at no charge. The portal address and phone number are found in the *Administrative Information* section.

The summary provided in this Handbook and in the Health Booklets is intended to provide an accurate explanation of how your benefit plans work. It is not intended to serve as any form of contract or plan document. If there is a discrepancy between the descriptions in this Handbook and the insurance contracts and plan documents, the contracts and plan documents will always govern.

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Your Health Plans

The hospitals' medical coverage is provided to eligible employees (and their eligible dependents) through Aetna or Kaiser Permanente. The plans give you the flexibility and support to actively manage both your health and your health care costs.

If you have questions or would like more information about your medical, prescription or mental health plan, call your carrier's member services number shown on your membership card and at the end of the *Administrative Information* section.

What's Offered

Types of Plans

You have three medical plan options for you and your eligible family members. Regardless of which plan you choose, you will receive free in-network preventive care, including annual physicals, well-woman exams, well-baby and well-child exams and immunizations.

Your medical plan choices are:

- Aetna Choice POS II with Health Savings Account (HSA), administered by Aetna
- Stanford Health Care Alliance (SHCA) plan, administered by Aetna
- Kaiser Permanente Health Maintenance Organization (HMO) plan.

ATTENTION KAISER PERMANENTE HMO PLAN MEMBERS

This section of the Handbook includes a high-level summary of the Kaiser Permanente HMO plan. For specific details about the plan, please see the Kaiser Permanente HMO Plan Evidence of Coverage Booklet.

When you enroll in a medical plan, you will automatically be covered under the vision plan through VSP. The eligible dependents you enroll in the medical plan will also automatically have coverage under VSP.

You also may choose to participate in a dental plan. You have these dental plan options:

- Delta Dental Basic PPO — a managed fee-for-service plan
- Delta Dental Buy-Up PPO — a managed fee-for-service plan that offers greater coverage than the Delta Dental Basic PPO
- DeltaCare® USA DHMO— a Dental Health Maintenance Organization (DHMO).

Using Your Plan

Several weeks after you enroll in the Aetna Choice POS II with Health Savings Account (HSA) or Stanford Health Care Alliance (SHCA) medical plan, you will receive two membership cards. You may order more cards online or by calling Aetna. Membership cards contain the telephone number to call if you have questions about your plan.

If you enroll in the Kaiser Permanente HMO plan, you will receive a card for each member of your family.

When you visit a provider or facility, you will need to provide your membership card.

How the Plans Work

Aetna Choice POS II with Health Savings Account (HSA)

The Aetna Choice Point of Service (POS) II with Health Savings Account (HSA) allows participants to visit any doctor or facility; however, you will always have the lowest out-of-pocket costs when you seek care through the Tier 1 network; you will pay more when you use Tier 2 providers and facilities; and you will pay the most when you use Tier 3 out-of-network providers and facilities. You must pay an annual deductible each calendar year before eligible medical expenses are paid by the plan.

WHO ADMINISTERS THE MEDICAL PLANS?

The Aetna Choice POS II with HSA and Stanford Health Care Alliance (SHCA) plans are administered by Aetna. The HMO plan is administered by Kaiser Permanente.

When you sign up for the Aetna Choice POS II with HSA, you will also be eligible for an HSA to offset the cost of out-of-pocket health care expenses. An HSA is an employee-owned tax-advantaged account that can be used to pay for qualified health expenses such as deductibles, coinsurance and copayments.

Stanford Health Care Alliance (SHCA)

In the SHCA plan, you must use the physicians and facilities within the SHCA network. When you see your provider, there are no deductibles or claims to file. If you go to a doctor outside of the SHCA network, and are not referred by your primary care physician (PCP) and pre-authorized through SHCA, you pay the full cost for the care you receive, except in the case of an emergency, or if the care is for your dependent who qualifies for the out-of-area benefit (see text box on this page).

Your PCP may refer you to Aetna in-network facilities, and you will pay a plan deductible and coinsurance. For facility care outside of the SHCA/Aetna network, you pay the full cost for the care you receive except in the case of an emergency. For detailed information on in-network and out-of-network facilities, and to select a PCP, please call your Member Care Specialist at 855-345-SHCA (7422).

SHCA participants are not eligible for a Health Savings Account. SHCA participants are eligible for the Health Incentive Account and/or may open a Health Care Flexible Spending Account to offset out-of-pocket costs.

DEPENDENTS WHO LIVE OUT OF AREA

If you have dependents who are attending college outside of the SHCA network area, they can use Aetna network providers (known as "out-of-area" providers) and pay the same applicable copays or coinsurance as they would for an in-network provider. However, claim amounts from "out-of-area" providers that apply to their deductible and out-of-pocket maximums will not apply to the family deductible and out-of-pocket maximum. Please call SHCA Member Care Services at 855-345-7422 or visit www.healthysteps4u.org for more details.

HMO

Health Maintenance Organizations (HMOs) provide a broad range of medical services at a low cost. To receive benefits, you must use your HMO's physicians, facilities and hospitals, except in a medical emergency. No benefits are payable for any non-emergency care you receive from a physician, facility or hospital outside your HMO network.

HMO participants are not eligible for a Health Savings Account. HMO participants are eligible for the Health Incentive Account and/or may open a Health Care Flexible Spending Account to offset out-of-pocket costs.

Medical Plan Coverage

Aetna Choice POS II with HSA

With the Aetna Choice POS II with HSA, you have the freedom to visit any licensed health care provider each time you need care. The choices you make affect the amounts you pay and the level of benefits you receive. In addition, certain benefit limitations may or may not apply. Generally:

- The Aetna Choice POS II with HSA has a three-tier provider network structure, which offers you even more providers and facilities from which to choose:
  - **Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network** — If you receive in-network care from providers in a Stanford Health Care, Stanford Children's Health and/or Stanford Health Care — ValleyCare Network facility, you will receive the highest level of coverage. As an added bonus, when you use the Stanford Health Care, Stanford Children's Health and/or Stanford Health Care — ValleyCare Network, inpatient hospital professional fees and outpatient surgery professional fees are covered at 100% after you've satisfied your deductible for the year and paid your copay. In-network preventive care services are covered at no cost to you.
  - **Tier 2: Aetna Choice POS II Network** — If you receive in-network care from providers who participate in the Aetna Choice POS II Network, you will receive the next highest level of benefits. In-network preventive care services are covered at no cost to you.
  - **Tier 3: Out-of-Network** — If you receive out-of-network care from providers who are not part of the Aetna Choice POS II Network, your benefits will be lower. Out-of-network preventive care services are typically not covered.

Find out which network a provider belongs to by calling the toll-free number listed on the back of the plan's membership card or visit www.aetna.com/dse/custom/shc.

You must pay an annual deductible each calendar year before eligible medical expenses are covered. All non-preventive services are subject to your deductible including medical, prescription drug and behavioral health services. (This means that until you meet your deductible, you will pay 100% of the cost for non-preventive medical services.) Keep in mind that separate in-network and out-of-network annual deductibles apply.

After you satisfy the deductible, the plan pays the majority of the cost. You pay a percentage of eligible medical expenses, called coinsurance, until you reach your annual out-of-pocket maximum[1]. Your annual out-of-pocket maximum is the most you would pay each calendar year for eligible medical expenses. Once you reach the annual out-of-pocket maximum, the plan pays 100% of your eligible medical expenses through the end of the calendar year. Again, separate in-network and out-of-network annual out-of-pocket maximums apply.

The Aetna Choice POS II with HSA also lets you contribute to a tax-advantaged HSA to help pay for eligible medical expenses or save for future medical expenses.

If you are enrolled in this plan, any wellness dollars earned by completing identified incentive activities will be contributed to your HSA. Wellness activities will help you earn money for eligible health care expenses and will be announced during annual open enrollment.

[1] The Aetna Choice POS II participants who use Stanford Health Care, Lucile Packard Children's Hospital Stanford and Stanford Health Care — ValleyCare Network hospital facilities will not have to pay coinsurance after the plan deductible for in-patient facility charges.

Schedule of Benefits

All health benefits shown on this Schedule of Benefits are subject to annual maximums, deductibles, copays, coinsurance and out-of-pocket maximums, if any.

Benefits are subject to all provisions of this plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the "What the Plan Covers" section in Aetna's Health Booklet for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Please refer to Aetna's Health Booklet for more details and a description of these services and prior authorization procedures.

Aetna Choice POS II with HSA

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
Annual Deductible per Calendar Year:			
• Single Coverage	$1,300		$2,600
• Family Coverage	$2,600		$5,200
Note: Medical, pharmacy and behavioral health expenses are subject to the same deductible			
Coinsurance: (unless otherwise stated below)			
• Paid by Plan After Deductible	100%	80%	60%
Annual Out-of-Pocket Maximum:			
• Single Coverage	$2,600		$5,200
• Family Coverage	$5,200		$10,400

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
Note: Medical, pharmacy and behavioral health expenses are subject to the same out-of-pocket maximum			
Acupuncture Treatment:			
• Maximum Visits per Calendar Year (combined Tier 1, Tier 2 and out-of-network)	12 visits	12 visits	12 visits
• Copay per Visit	$35	N/A	N/A
• Paid by Plan After Deductible	100% (less copay)	80%	60%
• Maximum Benefit per Visit	N/A	$30	$30
Ambulance Transportation:			
• Paid by Plan After In-Network Deductible	100%	100%	100% (UCR is waived for true emergency)
Chiropractic Services:			
• Maximum Visits per Calendar Year (combined Tier 1, Tier 2 and out-of-network)	30 visits	30 visits	30 visits
• Paid by Plan After Deductible	100%	80%	60%
Durable Medical Equipment:			
• Paid by Plan After Deductible	N/A	80%	60%
Emergency Services/Treatment:			
Urgent Care:			
• Paid by Plan After Deductible	100%	100%	100%
Emergency Room/Emergency Physicians In-Area:			
• Paid by Plan After In-Network Deductible	100%	80%	80%
Emergency Room/Emergency Physicians Out-of-Area:			
• Paid by Plan After In-Network Deductible	100%	80%	80%

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
Extended Care Facility Benefits Such as Skilled Nursing, Convalescent or Sub-Acute Facility:			
• Maximum Days per Calendar Year (combined Tier 2 and out-of-network)	N/A	100 days	100 days
• Paid by Plan After Deductible	N/A	80%	60%
Hearing Services: (if under age 22, covered under preventive care benefits; if age 22 or older, covered as shown below)			
Exams/Tests:			
• Paid by Plan After Deductible	100% (less copay)	80%	60%
Hearing Aids:			
• Maximum Benefit Every 2 Years	1 pair of hearing aids	1 pair of hearing aids	1 pair of hearing aids
• Paid by Plan After Deductible	100%	80%	60%
Home Health Care Benefits:			
• Maximum Visits per Calendar Year (combined Tier 2 and out-of-network)	N/A	100 visits	100 visits
• Paid by Plan After Deductible	N/A	80%	60%
Note: A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or up to four (4) hours of home health care services.			
Hospice Care Benefits:			
Hospice Services:			
• Paid by Plan After Deductible	N/A	80%	60%
Bereavement Counseling:			
• Paid by Plan After Deductible	N/A	80%	60%
Hospital Services: (precertification required)			
Pre-Admission Testing:			
• Paid by Plan After Deductible	100%	80%	60%

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
Inpatient Services/Inpatient Physician Charges, Room and Board Subject to the Payment of Semi-Private Room Rate or Negotiated Room Rate:			
• Paid by Plan After Deductible	100%	80%	60%; $300 admission penalty without precertification (waived if emergency admission)
Outpatient Surgery Facility Charges:			
• Copay per Visit	$200	N/A	N/A
• Paid by Plan After Deductible	100% (less copay)	80%	60%
Outpatient Surgery Physician Charges:			
• Paid by Plan After Deductible	100%	80%	60%
Outpatient Lab and X-ray Charges:			
• Paid by Plan After Deductible	100%	80%	60%
Infertility Care:			
• Paid by Plan After Deductible	Payable in accordance with the type of expense incurred and the place where the service is provided; includes counseling and consultation, infertility studies and tests and assisted reproductive technologies (procedures and medication).	80%; includes counseling and consultation, infertility studies and tests only	60%; includes counseling and consultation, infertility studies and tests only

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
	Lifetime maximum of $10,000 for medical expenses and $5,000 for pharmacy expenses		
Mental Health, Substance Abuse and Chemical Dependency Benefits: (provided through Optum)			
Inpatient Services/Physician Charges:			
• Paid by Plan After Deductible	100%	80%	60%
Residential Treatment:			
• Paid by Plan After Deductible	100%	80%	60%; $300 admission penalty without precertification (waived if emergency admission)
Partial Hospitalization Services/Physician Charges:			
• Paid by Plan After Deductible	100%	80%	60%
Outpatient Services/Physician Charges:			
• Copay per Visit	$20	N/A	N/A
• Paid by Plan After Deductible	100%	80%	60%
Physician Office Services:			
• Copay per Visit	$20 ($35 for specialist)	N/A	N/A
• Paid by Plan After Deductible	100%	80%	60%
Preventive/Routine Care Benefits: (see "Glossary of Terms" for definition of preventive treatment)			
Preventive/Routine Physical Exams at Appropriate Ages:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
Immunizations:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Preventive/Routine Diagnostic Tests, Lab and X-rays at Appropriate Ages:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Preventive/Routine Mammograms and Breast Exams:			
• Maximum Exams per Calendar Year	1 exam	1 exam	1 exam
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Preventive/Routine Pelvic Exams and Pap Test:			
• Maximum Exams per Calendar Year	1 exam	1 exam	1 exam
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Preventive/Routine PSA Test and Prostate Exams:			
• Maximum Exams per Calendar Year	1 exam	1 exam	1 exam
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Preventive/Routine Screenings/Services at Appropriate Ages and Gender:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
Preventive/Routine Colonoscopy, Sigmoidoscopy and Similar Routine Surgical Procedures Done for Preventive Reasons:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Note: The first colonoscopy of the year is covered under the preventive/routine benefit regardless of diagnosis.			
Preventive/Routine Hearing Exams:			
• Paid by Plan After Deductible	100% (deductible waived, coverage to age 21 only)	100% (deductible waived, coverage to age 21 only)	60% (coverage to age 21 only)
Preventive/Routine Alcohol and Substance Abuse, Tobacco Use, Obesity, Diet and Nutrition Counseling:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Temporomandibular Joint Disorder Benefits:			
• Paid by Plan After Deductible	N/A	80%	60%; $300 admission penalty without precertification (waived if emergency admission)
Therapy Services – Occupational/Physical/Speech:			
• Maximum Visits per Calendar Year (combined Tier 1, Tier 2 and out-of-network)	60 visits	60 visits	60 visits
• Copay per Visit	$35	N/A	N/A
• Paid by Plan After Deductible	100% (less copay)	80%	60%
Transgender Services			

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
• Paid by Plan After Deductible	Payable in accordance with the type of expense incurred and the place where the service is provided	80%	60%
Wigs, Toupees or Hairpieces: (allowed for hair loss resulting from chemotherapy or radiation therapy, alopecia areata, endocrine diseases or accidental injury)			
• Maximum Benefit per 1 Wig, 1 Toupee or 1 Hairpiece (up to $500 maximum every 2 years combined in- and out-of-network)	N/A	Every 2 years	Every 2 years
• Paid by Plan After Deductible	N/A	80%	80%
Women's Contraceptive Injections and Devices, such as IUDs and Implants: (including the insertion and removal)			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
All Other Covered Expenses:			
• Paid by Plan After Deductible	100% (where applicable)	80%	60%

[2] Out-of-network means outside of the Tier 2 network. Usual, Customary and Reasonable (UCR) charges are the fees normally charged for medical services or supplies in a particular geographic location.

Notes: Refer to the "Provider Network" section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined maximum benefit for services that the covered person receives from all in-network and out-of-network providers and facilities.

Transplant Schedule of Benefits: Aetna Choice POS II with HSA	Tier 1: Stanford Health Care and Stanford Children's Health Network and Stanford Health Care — ValleyCare	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[3]
Transplant Services at an Institute of Excellence (IOE) Transplant Facility: (benefits are provided only if service is received at an IOE)			
Transplant Services:			
• Paid by Plan After Deductible	100%	80%	N/A
Travel and Housing[4]:			
• Maximum Benefit per Transplant	$10,000 (combined maximum)		N/A
• Paid by Plan After Deductible	100%	80%	N/A

[3] Out-of-Network means out of the Tier 2 network. Usual, Customary and Reasonable (UCR) charges are the fees normally charged for medical services or supplies in a particular geographic location.

[4] Travel and housing at designated transplant facility for up to one year from date of transplant with prior authorization.

Note: If a transplant is performed at a Stanford Health Care or Lucile Packard Children's Hospital Stanford facility, you are not required to use an Institute of Excellence (IOE) transplant facility.

What the Plan Covers

Pre-Existing Conditions

The health plans offered by the hospitals treat health conditions you or a family member had prior to your coverage date the same as any other covered health condition.

Preventive Care

Preventive care services are recommended screenings for proactive wellness management. These services help identify health risks before they become greater health issues. By identifying risks early, you can avoid greater health complications as well as save on the costs of managing more complicated health issues.

The Aetna Choice POS II with HSA covers preventive care at 100% when you receive it from an in-network provider. The plan covers charges for routine preventive care, including immunizations of a dependent for the first two years of life. Routine preventive care means health care assessments, wellness visits and any related services.

While your doctor will determine the tests that are right for you based on your age, gender and family history, below is a list of items covered by your preventive care benefits. This list is not all inclusive and is subject to change according to the recommendations of the United States Preventive Services Task Force, Health Resources and Services Administration:

- Periodic well-baby and well-child visits, depending on age
- Immunizations (as appropriate by age):
  - Diphtheria, tetanus and acellular pertussis (DTAP)
  - Hepatitis A & B
  - HPV
  - Influenza
  - Measles-mumps-rubella (MMR)
  - Meningococcal (MCV4)
  - Varicella (chickenpox).
- Screenings (as appropriate by age):
  - Blood pressure
  - Cholesterol
  - Mammography screening
  - Osteoporosis screening
  - Pap smear and pelvic exam
  - Prostate screening (PSA)
  - Colorectal cancer screenings.

Urgent Care

Urgent care is defined as the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care, but is not serious enough to warrant a visit to an emergency room. Examples include upper respiratory or urinary tract infections, sprains, strains, GI disorders, rashes and insect bites.

Often, urgent care centers are not open on a continuous basis, unlike a hospital emergency room that would be open at all times.

Emergency Care

Your first priority in a medical emergency is to get the care you need right away, without worrying about going to an in-network provider. In a true medical emergency, all three medical plans pay in-network benefits, even if the care is provided by an out-of-network provider. A medical emergency is a sudden illness or injury serious enough to threaten your life or cause permanent damage if it is not treated immediately. Emergency room copayments may apply.

Within 48 hours of seeking emergency medical care or as soon as it is medically possible, you or a family member must contact your medical plan to discuss your continuing treatment.

Home Health Care

Home health care services are provided for patients who are unable to leave their home, as determined by the utilization review organization. Covered persons must obtain prior authorization in advance before receiving services. Please refer to the "Home Health Care" section of Aetna's Health Booklet for more details.

Covered services can include:

- Home visits instead of visits to the provider's office that do not exceed the Usual, Customary and Reasonable charge to perform the same service in a provider's office
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period
- Nutrition counseling provided by or under the supervision of a registered dietitian
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist
- Medical supplies, drugs or medication prescribed by a physician and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital.

A home health care visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if medically necessary) or a single visit by a therapist or a registered dietician.

Exclusions

In addition to the items listed in the "Home Health Care Limitations" section of Aetna's Health Booklet, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services
- Supportive environment materials such as handrails, ramps, air conditioners or telephones
- Services performed by family members or volunteer workers

- "Meals on Wheels" or similar food services
- Separate charges for records, reports or transportation
- Expenses for the normal necessities of living such as food, clothing and household supplies
- Legal and financial counseling services, unless otherwise covered under this plan.

Transplant Benefits

The plan will pay for covered expenses incurred by a covered person at a designated transplant facility for an illness or injury, subject to any deductibles, plan participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual, Customary and Reasonable charge or the plan's negotiated rate.

It will be the covered person's responsibility to obtain prior authorization for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual plan provisions. The approved transplant and medical criteria for such transplant must be medically necessary for the medical condition for which the transplant is recommended. Please see the Aetna Choice POS II with HSA plan documents for more information.

What the Plan Does Not Cover

Unless exceptions to the following exclusions are specifically made elsewhere in this section of the Handbook, no benefits are provided for the following services or supplies which are:

- For or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a participating hospice agency and except as medically necessary.
- For rehabilitation services, except as specifically provided in the "Services for Treatment of Illness or Injury," "Home Health Care Benefits," "Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)" and "Hospice Program Benefits" sections.
- For or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, custodial, maintenance, domiciliary care or residential care except as provided under hospice program benefits (see "Hospice Program Benefits" for exception).
- Performed in a hospital by house officers, residents, interns and others in training.
- Performed by a close relative or by a person who ordinarily resides in the covered participant's home.
- For any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a mental health condition.

- For or incident to services by non-preferred providers, except as may be provided for medically necessary emergency services.
- For any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine or any other language assistive devices, except as specifically listed under prosthetic appliances benefits.
- For routine physical examinations, except as specifically listed under preventive health benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment or insurance unless the examination is substituted for the annual health appraisal exam.
- For or incident to speech therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness except as specifically listed under home health care benefits, speech therapy benefits and hospice program benefits.
- For drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met.
- For or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs or nutritional counseling except as specifically provided for under diabetes care benefits. This exclusion shall not apply to medically necessary services which the plan is required by law to cover for severe mental illnesses or serious emotional disturbances of a child.
- For sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions.
- For callus, corn paring or excision and toenail trimming except as may be provided through a participating hospice agency; over-the-counter shoe inserts or arch supports or any type of massage procedure on the foot.
- Which are experimental or investigational in nature, except for services for participants who have been accepted into an approved clinical trial for cancer as provided under clinical trial for cancer benefits.
- For learning disabilities, behavioral problems, social skills training/therapy or testing for intelligence or learning disabilities. This exclusion shall not apply to medically necessary services which the plan is required by law to cover for severe mental illnesses or serious emotional disturbances of a child.
- Hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation.

- For dental care or services incident to the treatment, prevention or relief of pain or dysfunction of the temporomandibular joint and/or muscles of mastication, except as specifically provided under medical treatment of teeth, gums, jaw joints or jaw bones benefits and hospital benefits (facility services).

- For or incident to services and supplies for treatment of the teeth and gums (except for tumors and dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures) and associated periodontal structures including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays and topical fluoride treatment, except when used with radiation therapy to the oral cavity, fillings and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses, except as specifically provided under medical treatment of teeth, gums, jaw joints or jaw bones benefits and hospital benefits (facility services).

- Incident to organ transplant, except as explicitly listed under transplant benefits.

- For cosmetic surgery or any resulting complications, except that benefits are provided for medically necessary services to treat complications of cosmetic surgery (e.g., infections or hemorrhages), when reviewed and approved by the plan consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:

  - Lower eyelid blepharoplasty
  - Spider veins
  - Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing and abrasive procedures)
  - Hair removal by electrolysis or other means
  - Reimplantation of breast implants originally provided for cosmetic augmentation
  - Voice modification surgery.

- For reconstructive surgery and procedures where there is another more appropriate covered surgical procedure or when the surgery or procedure offers only a minimal improvement in the appearance of the enrollee (e.g., spider veins). In addition, no benefits will be provided for the following surgeries or procedures unless for reconstructive surgery:

  - Surgery to excise, enlarge, reduce or change the appearance of any part of the body
  - Surgery to reform or reshape skin or bone
  - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging or excessive on any part of the body

- Hair transplantation
- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

- For penile implant devices and surgery, and any related services, except for any resulting complications.
- Not specifically listed as a benefit and medically necessary service.
- For patient convenience items such as telephone, television, guest trays and personal hygiene items.
- For which the participant is not legally obligated to pay or for services for which no charge is made.
- Incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation.

  However, if Aetna provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by the plan for the treatment of such injury or disease.
- In connection with private duty nursing, except as provided under home health care benefits and home infusion/home injectable therapy benefits, except as provided through a participating hospice agency.
- For prescription and non-prescription food and nutritional supplements, except as provided under home infusion/home injectable therapy benefits, and PKU-related formulas and special food products benefit, except as provided through a participating hospice agency.
- For home testing devices and monitoring equipment, except as specifically provided under durable medical equipment benefits.
- For genetic testing, except as described under outpatient X-ray, pathology and laboratory benefits and pregnancy and maternity care benefits.
- For non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under home health care benefits, home infusion/home injectable therapy benefits, hospice program benefits, diabetes care benefits, durable medical equipment benefits and prosthetic appliances benefits.

- For services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy benefits under the hospitals' health plan.
- For services provided by an individual or entity that is not licensed, certified or otherwise authorized by the state to provide health care services, or is not operating within the scope of such license, certification or state authorization, except as specifically stated herein.
- For massage therapy that is not physical therapy or a component of a multimodality rehabilitation treatment plan.
- For Christian Science practitioner benefits.
- For prescribed drugs and medicines for outpatient care, except as provided through a participating hospice agency when the participant is receiving hospice services and except as may be provided under the outpatient prescription drugs supplement or home infusion/home injectable therapy benefits in the "Covered Services" section.
- For services not authorized by the plan.

Medical Necessity Exclusion

The benefits of this plan are intended only for services that are medically necessary. Because a physician or other provider may prescribe, order, recommend or approve a service or supply does not, in itself, make it medically necessary even though it is not specifically listed as an exclusion or limitation. The plan reserves the right to review all claims to determine if a service or supply is medically necessary. The plan may use the services of doctor of medicine consultants, peer review committees of professional societies or hospitals and other consultants to evaluate claims. The plan may limit or exclude benefits for services which are not necessary.

Stanford Health Care Alliance (SHCA)

The Stanford Health Care Alliance is a health care plan that puts the best Stanford affiliated team in place — across Stanford Health Care (includes Stanford Hospital, Stanford Health Care — ValleyCare, Stanford Clinics, University Healthcare Alliance and Affinity), Stanford Children's Health (includes Lucile Packard Children's Hospital Stanford and Packard Children's Health Alliance) and Aetna's hospital and ancillary network — to provide you with world-class, integrated care that supports your best health.

In the SHCA plan, you must use the physicians and facilities within the SHCA network. When you see your provider, there are no deductibles or claims to file. If you go to a doctor outside of the SHCA network, and are not referred by your PCP and pre-authorized through SHCA, you pay the full cost for the care you receive, except in the case of an emergency, or if the care is for your dependent who qualifies for the out-of-area benefit (see text box on this page).

Your PCP may refer you to Aetna's in-network facilities and you will pay a plan deductible and coinsurance.[5] For facility care outside of the SHCA/Aetna network, you pay the full cost for the care you receive. For detailed information on in-network and out-of-network facilities, and to select a PCP, please call your Member Care Specialist at 855-345-SHCA (7422).

DEPENDENTS WHO LIVE OUT OF AREA

If you have dependents who are attending college outside of the SHCA network area, they can use Aetna network providers (known as "out-of-area" providers) and pay the same applicable copays or coinsurance as they would for an in-network provider. However, claim amounts from "out-of-area" providers that apply to their deductible and out-of-pocket maximums will not apply to the family deductible and out-of-pocket maximum. Please call SHCA Member Care Services at 855-345-7422 or visit www.healthysteps4u.org for more details.

- Preventive care services like annual physical exams and certain types of screenings are provided at no cost to you.
- You are responsible for all medical expenses each year until you reach your annual deductible amount ($400/individual or $1,000/family).

[5] SHCA participants who use Stanford Health Care, Lucile Packard Children's Hospital Stanford and Stanford Health Care — ValleyCare Network hospital facilities will not have to pay a deductible or coinsurance.

Annual Deductible	Coinsurance	Out-of-Pocket Maximum
$400/person $1,000/family	Varies based on service	$1,800/individual $3,600/family

- Once you've reached your annual deductible, you will pay coinsurance or copays for covered expenses until you reach your out-of-pocket maximum for the year ($1,800/individual or $3,600/family).

- When you reach your out-of-pocket maximum, you will pay nothing for the rest of the year for covered services.
- Prescription drug coverage and mental health and substance abuse treatment services are provided by Aetna.
- You pay a set copay for prescription drugs. Prescription drugs may only be filled at an Aetna-affiliated pharmacy.

When you enroll in the SHCA plan, you become eligible for a Health Incentive Account (HIA). Once you earn wellness dollars by completing identified incentive activities, the hospitals will open an HIA and contribute to it on your behalf. Wellness activities will help you earn money for eligible health care expenses. Any funds remaining in this account at the end of the calendar year will be lost. Wellness activity incentives will be announced during annual open enrollment.

For more information about the Stanford Health Care Alliance, including a directory of in-network providers and facilities, visit www.stanfordhealthcarealliance.org.

Schedule of Benefits

All health benefits shown on this Schedule of Benefits are subject to annual maximums, deductibles, copays, coinsurance and out-of-pocket maximums, if any.

Benefits are subject to all provisions of this plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the “What the Plan Covers” and “Medical Plan Exclusions” sections in Aetna’s Health Booklet for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Please refer to the “What the Plan Covers” section in Aetna’s Health Booklet for more details, a description of these services and prior authorization procedures.

Stanford Health Care Alliance (SHCA)

Covered Expense	SHCA Network
Annual Deductible per Calendar Year:	
• Single Coverage	$400
• Family Coverage	$1,000
Plan Participation Rate: (unless otherwise stated below)	
• Paid by Plan After Satisfaction of Deductible	90%
Annual Out-of-Pocket Maximum:	
• Single Coverage	$1,800
• Family Coverage	$3,600

Covered Expense	SHCA Network
Acupuncture Treatment:	
• Copay per Visit	$35
• Maximum Visits per Calendar Year	12 visits
• Maximum Benefit per Visit	N/A
• Paid by Plan After Deductible	100% (deductible waived)
Ambulance Transportation:	
• Paid by Plan After Deductible	100% (deductible waived)
Chiropractic Services:	
• Copay per Visit	$35
• Maximum Visits per Calendar Year	30 visits
• Paid by Plan After Deductible	100% (deductible waived)
Durable Medical Equipment:	
• Paid by Plan After Deductible	90%
Emergency Services/Treatment:	
Urgent Care:	
• Copay per Visit	$20
• Paid by Plan After Deductible	100% (deductible waived)
Emergency Room/Emergency Physicians:	
• Copay per Visit	$200
• Paid by Plan After In-Network Deductible	100% (deductible waived)
Extended Care Facility Benefits Such as Skilled Nursing, Convalescent or Sub-Acute Facility:	
• Maximum Days per Calendar Year	100 days
• Paid by Plan After Deductible	90%
Hearing Services:	
Exams/Tests:	
• Copay per Visit	$35
• Paid by Plan After Deductible	100% (deductible waived)
Hearing Aids:	
• Maximum Benefit per Ear Every 2 Years	1 pair of hearing aids
• Paid by Plan After Deductible	90%
Home Health Care Benefits:	
• Maximum Visits per Calendar Year	100 visits

Covered Expense	SHCA Network
• Paid by Plan After Deductible	90%
Note: A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or up to four hours of home health care services.	
Hospice Care Benefits:	
Hospice Services:	
• Paid by Plan After Deductible	90%
Bereavement Counseling:	
• Paid by Plan After Deductible	90%
Hospital Services:	
Pre-Admission Testing:	
• Paid by Plan After Deductible	90%
Inpatient Services/Inpatient Room and Board Subject to the Payment of Semi-Private Room Rate or Negotiated Room Rate:	
• Paid by Plan After Deductible	90%
Inpatient Services/Inpatient Physician Charges:	
• Paid by Plan After Deductible	100% (deductible waived)
Inpatient Facility Charges Incurred at Stanford Health Care, Lucile Packard Children's Hospital Stanford or Stanford Health Care – ValleyCare:	
• Paid by Plan After Deductible	100% (deductible waived)
Outpatient Surgery Facility Charges:	
• Paid by Plan After Deductible	90%
Outpatient Surgery Facility Charges Incurred at Stanford Health Care, Lucile Packard Children's Hospital Stanford or Stanford Health Care – ValleyCare:	
• Copay per Visit	$200
• Paid by Plan After Deductible	100% (deductible waived)
Outpatient Surgery Physician Charges:	
• Paid by Plan After Deductible	100% (deductible waived)
Basic and Complex Outpatient Lab and X-ray Charges:	
• Paid by Plan After Deductible	90%
Basic Outpatient Lab and X-ray Charges Incurred at Stanford Health Care, Lucile Packard Children's Hospital Stanford, Stanford Health Care – ValleyCare or SHCA Physician's Office:	
• Copay per Visit	$25
• Paid by Plan After Deductible	100% (deductible waived)

Covered Expense	SHCA Network
Complex Outpatient Lab and X-ray Charges Incurred at Stanford Health Care, Lucile Packard Children's Hospital Stanford, Stanford Health Care – Valley Care or SHCA Physician's Office:	
• Copay per Visit	$100
• Paid by Plan After Deductible	100% (deductible waived)
Infertility Care:	
• Paid by Plan After Deductible	Payable in accordance with the type of expense incurred and the place where the service is provided; includes counseling and consultation, infertility studies and tests and assisted reproductive technologies (procedures and medication). Lifetime maximum of $10,000 for medical expenses and $5,000 for pharmacy expenses
Mental Health, Substance Abuse and Chemical Dependency Benefits:	
Inpatient Services/Physician Charges:	
• Paid by Plan After Deductible	100% (deductible waived)
Inpatient, Partial Hospitalization, Outpatient and Outpatient Observation Facility Charges:	
• Paid by Plan After Deductible	90%
Residential Treatment:	
• Paid by Plan After Deductible	90%
Inpatient, Partial Hospitalization, Residential Treatment, Outpatient and Outpatient Observation Facility Charges Incurred at Stanford Health Care, Lucile Packard Children's Hospital Stanford or Stanford Health Care – ValleyCare:	
• Paid by Plan After Deductible	100% (deductible waived)
Outpatient Services/Physician Charges:	
• Copay per Visit	$20
• Paid by Plan After Deductible	100% (deductible waived)
Physician Office Visit:	
Primary Care Physician Office Visit:	
• Copay per Visit	$20
• Paid by Plan After Deductible	100% (deductible waived)

Covered Expense	SHCA Network
Specialist Office Visit:	
• Copay per Visit	$35
• Paid by Plan After Deductible	100% (deductible waived)
Allergy Testing:	
• Copay per Visit	$20 for PCP or $35 for specialist
• Paid by Plan After Deductible	100% (deductible waived)
Allergy Injections:	
If Billed without an Office Visit:	
• Copay per Visit	N/A
• Paid by Plan After Deductible	100% (deductible waived)
If Billed with an Office Visit:	
• Copay per Visit	$20 for PCP or $35 for specialist
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine Care Benefits: (see "Glossary of Terms" for definition of preventive treatment)	
Preventive/Routine Physical Exams at Appropriate Ages:	
• Paid by Plan After Deductible	100% (deductible waived)
Immunizations:	
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine Diagnostic Tests, Lab and X-rays at Appropriate Ages:	
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine Mammograms and Breast Exams:	
• Maximum Exams per Calendar Year	1 exam
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine Pelvic Exams and Pap Test:	
• Maximum Exams per Calendar Year	1 exam
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine PSA Test and Prostate Exams:	
• Maximum Exams per Calendar Year	1 exam
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine Screenings/Services at Appropriate Ages and Gender:	
• Paid by Plan After Deductible	100% (deductible waived)

Covered Expense	SHCA Network
Preventive/Routine Colonoscopy, Sigmoidoscopy and Similar Routine Surgical Procedures Done for Preventive Reasons:	
• Paid by Plan After Deductible	100% (deductible waived)
Note: The first colonoscopy of the year is covered under the preventive/routine benefit regardless of diagnosis.	
Preventive/Routine Hearing Exams:	
• Paid by Plan After Deductible	100% (deductible waived)
Transgender Services:	
• Paid by Plan After Deductible	Payable in accordance with the type of expense incurred and the place where the service is provided
Temporomandibular Joint Disorder Benefits:	
• Paid by Plan After Deductible	90%
Therapy Services – Occupational/Physical/Speech:	
• Maximum Visits per Calendar Year	60 visits
• Copay per Visit	$35
• Paid by Plan After Deductible	100% (deductible waived)
Wigs, Toupees or Hairpieces:	
• Maximum Benefit per Wig, Toupee or Hairpiece	$500
• Maximum Benefit per Treatment Every 2 Years	1 wig, toupee or hairpiece
• Paid by Plan After Deductible	90%
Women's Contraceptive Injections and Devices, such as IUDs and Implants: (including the insertion and removal)	
• Paid by Plan After Deductible	100% (deductible waived)
All Other Covered Expenses:	
• Paid by Plan After Deductible	90%

Transplant Schedule of Benefits: SHCA	
Transplant Services at an Institute of Excellence (IOE) Transplant Facility:	
Transplant Services:	
• Paid by Plan After Deductible	90%
Travel and Housing:	
• Maximum Benefit per Transplant	$10,000

Transplant Schedule of Benefits: SHCA	
Transplant Services at Stanford Health Care, Lucile Packard Children's Hospital Stanford or Stanford Health Care – ValleyCare:	
Transplant Services:	
• Paid by Plan After Deductible	100% (deductible waived)
Travel and Housing at Designated Transplant Facility for up to One Year from Date of Transplant with prior authorization.	

What the Plan Covers

Pre-Existing Conditions

The hospitals treat health conditions you or a family member had prior to your coverage date the same as any other covered health condition.

Preventive Care

Preventive care services are recommended screenings for proactive wellness management. These services help identify health risks before they become greater health issues. By identifying risks early, you can avoid greater health complications as well as save on the costs of managing more complicated health issues.

The SHCA Plan covers preventive care at 100% when you receive it from an in-network provider.

The plan covers charges for routine preventive care, including immunizations of a dependent for the first two years of life. Routine preventive care means health care assessments, wellness visits and any related services.

While your doctor will determine the tests that are right for you based on your age, gender and family history, below is a list of items covered by your preventive care benefits. This list is not all inclusive and is subject to change according to the recommendations of the United States Preventive Services Task Force, Health Resources and Services Administration.

- Periodic well-baby and well-child visits, depending on age
- Immunizations (as appropriate by age):
  - Diphtheria, tetanus and acellular pertussis (DTAP)
  - Hepatitis A & B
  - HPV
  - Influenza
  - Measles-mumps-rubella (MMR)

  - Meningococcal (MCV4)
  - Varicella (chickenpox).
- Screenings (as appropriate by age):
  - Blood pressure
  - Cholesterol
  - Mammography screening
  - Osteoporosis screening
  - Pap smear and pelvic exam
  - Prostate screening (PSA)
  - Colorectal cancer screenings.

Urgent Care

Urgent care is defined as the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. Examples include upper respiratory or urinary tract infections, sprains, strains, GI disorders, rashes and insect bites.

Often, urgent care centers are not open on a continuous basis, unlike a hospital emergency room that would be open at all times.

Emergency Care

Your first priority in a medical emergency is to get the care you need right away, without worrying about going to an in-network provider. In a true medical emergency, all three medical plans pay in-network benefits even if the care is received by an out-of-network provider. A medical emergency is a sudden illness or injury serious enough to threaten your life or cause permanent damage if it is not treated immediately. Emergency room copayments may apply.

Within 48 hours of seeking emergency medical care, or as soon as it is medically possible, you or a family member must contact your medical plan to discuss your continuing treatment.

Home Health Care

Home health care services are provided for patients who are unable to leave their home, as determined by the utilization review organization. Covered persons must obtain prior authorization in advance before receiving services. Please refer to the “Home Health Care” section of Aetna’s Health Booklet for more details.

Covered services can include:

- Home visits instead of visits to the provider's office that do not exceed the Usual, Customary and Reasonable charge to perform the same service in a provider's office
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period
- Nutrition counseling provided by or under the supervision of a registered dietitian
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist
- Medical supplies, drugs or medication prescribed by a physician and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital.

A home health care visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if medically necessary) or a single visit by a therapist or a registered dietician.

Exclusions

In addition to the items listed in the "Home Health Care Limitations" section of Aetna's Health Booklet, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services
- Supportive environment materials such as handrails, ramps, air conditioners or telephones
- Services performed by family members or volunteer workers
- "Meals on Wheels" or similar food services
- Separate charges for records, reports or transportation
- Expenses for the normal necessities of living such as food, clothing and household supplies
- Legal and financial counseling services, unless otherwise covered under this plan.

Transplant Benefits

The plan will pay for covered expenses incurred by a covered person at a designated transplant facility for an illness or injury, subject to any deductibles, plan participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual, Customary and Reasonable charge or the plan's negotiated rate.

It will be the covered person's responsibility to obtain prior authorization for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services.

Benefits may also be subject to reduced levels as outlined in individual plan provisions. The approved transplant and medical criteria for such transplant must be medically necessary for the medical condition for which the transplant is recommended. Please see the “Transplant Benefits” section of Aetna’s Health Booklet for more information.

What the Plan Does Not Cover

Exclusions, including complications from excluded items, are not considered covered benefits under this plan and will not be considered for payment as determined by the plan unless medically necessary.

The plan does not pay for expenses incurred for the following unless otherwise stated below:

- Acts of war: Injury or illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, war or acts of war, whether declared or undeclared
- Alternative/complementary treatment: Includes treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the plan
- Appointments missed: An appointment the covered person did not attend
- Aquatic therapy unless provided by a qualified physical therapist, doctor of medicine, occupational therapist or chiropractor
- Assistance with activities of daily living
- Assistant surgeon services, unless determined medically necessary by the plan
- Augmentation communication devices
- Auto excess: Illness or bodily injury for which there is a medical payment or expense coverage provided or payable under any automobile coverage
- Before enrollment and after termination: Services, supplies or treatment rendered before coverage begins under this plan or after coverage ends
- Biofeedback services
- Blood donor expenses
- Blood pressure cuffs/monitors
- Cardiac rehabilitation beyond Phase II including self-regulated physical activity that the covered person performs to maintain health that is not considered to be a treatment program

- Chelation therapy, except in the treatment of conditions considered medically necessary, medically appropriate and not experimental or investigational for the medical condition for which the treatment is recognized
- Claims received later than 12 months from the date of service
- Claims not specifically listed as a benefit
- Contraceptive products unless covered elsewhere in this document
- Cosmetic treatment, cosmetic surgery or any portion thereof, unless the procedure is otherwise listed as a covered benefit
- Court-ordered: Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation or custody or visitation evaluation, unless such treatment or therapy is normally covered by this plan; the cost of classes ordered after a driving-while-intoxicated conviction or other classes ordered by the court
- Criminal activity: Illness or injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place
- Custodial care as defined in the “Glossary of Terms” section of this Handbook
- Dental services: The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to hospital charges including professional charges for X-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an accident. Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances
- Dental implants including preparation for implants
- Duplicate services and charges or inappropriate billing including the preparation of medical reports and itemized bills
- Education: Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics
- Environmental devices: Environmental items such as but not limited to air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers or vacuum devices
- Examinations: Examinations for employment, insurance, licensing or litigation purposes

- Excess charges: Charges or the portion thereof which are in excess of the Usual, Customary and Reasonable charge, the negotiated rate or fee schedule
- Experimental, investigational or unproven: Services, supplies, medicines, treatment, facilities or equipment which the plan determines are experimental, investigational or unproven, including administrative services associated with experimental, investigational or unproven treatment. This does not include qualifying clinical trials as described in the "What The Plan Covers" section of Aetna's Health Booklet
- Extended care: Any extended care facility services which exceed the appropriate level of skill required for treatment as determined by the plan
- Financial counseling
- Fitness programs: General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building
- Foot care (podiatry): Routine foot care
- Foreign services received outside the United States when the sole purpose of travel is to obtain medical services and/or supplies
- Genetic counseling other than that based on medical necessity unless covered elsewhere in this Handbook
- Genetic testing unless covered elsewhere in this Handbook
- Growth hormones
- Hearing services: Implantable hearing devices unless covered elsewhere in this Handbook
- Home births and associated costs
- Home modifications: Modifications to your home or property such as but not limited to escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts or ramps
- Infant formula not administered through a tube as the sole source of nutrition for the covered person
- Lamaze classes or other child birth classes
- Learning disability: Non-medical treatment including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a learning disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to plan provisions

- Liposuction, regardless of purpose
- Maintenance therapy if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or if clinical evidence indicates that a plateau has been reached in terms of improvement from such services
- Mammoplasty or breast augmentation unless covered elsewhere in this Handbook
- Marriage counseling
- Massage therapy unless provided by a qualified physical therapist, doctor of medicine, occupational therapist or chiropractor
- Maximum benefit: Charges in excess of the maximum benefit allowed by the plan
- Military: A military-related illness or injury to a covered person on active military duty, unless payment is legally required
- Nocturnal Enuresis Alarm (bed wetting)
- Non-custom-molded shoe inserts
- Non-professional care: Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license
- Not medically necessary: Services, supplies, treatment, facilities or equipment which the plan determines is not medically necessary. Services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition or maintain the current health status of the covered person. See also maintenance therapy, above
- Nursery and newborn expenses for grandchildren of a covered employee or spouse
- Nutrition counseling unless covered elsewhere in this Handbook
- Nutritional supplements, vitamins and electrolytes except as listed under the covered benefits
- Over-the-counter medication, products, supplies or devices unless covered elsewhere in this Handbook
- Palliative foot care
- Panniculectomy/abdominoplasty unless determined by the plan to be medically necessary

- Personal comfort: Services or supplies for personal comfort or convenience such as but not limited to private rooms, televisions, telephones and guest trays
- Pharmacy consultations: Charges for or relating to consultative information provided by a pharmacist regarding a prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects and the like
- Private duty nursing services
- Reconstructive surgery when performed only to achieve a normal or nearly normal appearance and not to correct an underlying medical condition or impairment, as determined by the plan, unless covered elsewhere in this Handbook
- Return to work/school: Telephone or internet consultations or completion of claim forms or forms necessary for the return to work or school
- Reversal of sterilization: Procedures or treatments to reverse prior voluntary sterilization
- Room and board fees when surgery is performed other than at a hospital or surgical center
- Self-inflicted injuries unless due to a medical condition (physical or mental) or domestic violence
- Services at no charge or cost: Services which the covered person would not be obligated to pay in the absence of this plan or which are available to the covered person at no cost, or which the plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law
- Services that should legally be provided by a school
- Services provided by a close relative
- Sex therapy
- Sexual function: Non-surgical and surgical procedures and prescription drugs (unless covered under the “Prescription Benefits” section of this Handbook) in connection with treatment for male or female impotence
- Standby surgeon charges
- Subrogation: Charges for illness or injuries suffered by a covered person due to the action or inaction of any third party if the covered person fails to provide information as specified in the “Expenses for Which a Third Party May Be Responsible (Subrogation)” section

- Surrogate parenting and gestational carrier services: Any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges incurred by a covered person acting as a surrogate parent
- Taxes: Sales taxes, shipping and handling unless covered elsewhere in this Handbook
- Telemedicine: Telephone or internet consultations
- Transportation: Transportation services which are solely for the convenience of the covered person, the covered person's close relative or the covered person's physician
- Travel: Travel costs, whether or not recommended or prescribed by a physician, unless authorized in advance by the plan
- Vision care unless covered elsewhere in this Handbook
- Vitamins, minerals and supplements, even if prescribed by a physician, except for vitamin B-12 injections and IV iron therapy that are prescribed by a physician for medically necessary purposes
- Vocational services: Vocational and educational services rendered primarily for training or education purposes; work hardening, work conditioning and industrial rehabilitation services rendered for injury prevention education or return-to-work programs
- Weekend admissions to hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the plan, unless the admission is deemed an emergency or for care related to pregnancy that is expected to result in childbirth
- Weight control: Treatment, services or surgery for weight control, whether or not prescribed by a physician or associated with an illness, except as specifically stated for preventive counseling. This does not include specific services for morbid obesity as listed in the "What The Plan Covers" section of Aetna's Health Booklet
- Wigs, toupees, hairpieces, hair implants, transplants, hair weaving or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this Handbook
- Workers' compensation: An illness or injury arising out of or in the course of any employment for wage or profit, including self-employment, for which the covered person was or could have been entitled to benefits under any workers' compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.

The plan does not apply exclusions based upon the source of the injury to treatment listed in the "Covered Medical Benefits" section when the plan has information that the injury is due to a medical condition (physical or mental) or domestic violence.

The plan does not limit a covered person's right to choose his or her own medical care. If a medical expense is not a covered benefit or is subject to a limitation or exclusion, a covered person still has the right and privilege to receive such medical service or supply at the covered person's own personal expense.

Kaiser Permanente HMO

After you enroll in the Kaiser Permanente HMO plan, you may access the Kaiser Permanente HMO Plan Evidence of Coverage (EOC) Booklet through their website at http://my.kp.org/stanfordmed.

You may also contact the HealthySteps benefits service center for a paper copy of the EOC Booklet to be mailed to you at no charge, or you can visit www.HealthySteps4u.org. It has complete information about what is covered, including any limitations or exclusions that might apply. Together, the EOC and this Handbook are your Summary Plan Description (SPD) for your Kaiser Permanente HMO plan. Keep them handy so you can refer to them when you have a question.

Additionally, Kaiser Permanente encourages members to choose a plan physician to coordinate your health care needs. To learn how to choose a plan physician, call the Kaiser Permanente member services number listed at the end of the *Administrative Information* section.

When you enroll in the Kaiser Permanente HMO plan, you become eligible for a Health Incentive Account (HIA). Once you earn wellness dollars by completing identified incentive activities, the hospitals will open an HIA and contribute to it on your behalf. Wellness activities will help you earn money for eligible health care expenses. Any funds remaining in this account at the end of the calendar year will be lost. Wellness activity incentives will be announced during annual open enrollment.

Schedule of Benefits

Please see your Kaiser Permanente HMO Plan Evidence of Coverage Booklet for more information about the Schedule of Benefits.

Prescription Drug Benefits

Aetna Choice POS II with HSA

Your prescription drug benefits are administered by CVS/caremark. You do not need to enroll to participate in the CVS/caremark prescription benefit; enrollment is automatic when you enroll in the Aetna Choice POS II with HSA.

CVS/caremark

If you are enrolled in the Aetna Choice POS II with HSA, you can fill short-term prescriptions at retail pharmacies and long-term prescriptions through the CVS/caremark mail-order program.

The amount you pay per prescription depends on whether the drug is generic, formulary or non-formulary and whether you use a participating or non-participating pharmacy. You receive the highest benefit level when you use the mail-order service.

Prescription Drug Copays and Coinsurance

Medication Type	Aetna Choice POS II with HSA	
	In-Network	Out-of-Network
Retail Generic		
• Preventive	$0 (no deductible)	60% after deductible
• Non-Preventive	80% after deductible	60% after deductible
Retail Formulary Brand		
• Preventive	$0 (no deductible)	60% after deductible
• Non-Preventive	80% after deductible	60% after deductible
Retail Non-Formulary Brand		
• Preventive	$50 copay (no deductible)	60% after deductible
• Non-Preventive	80% after deductible	60% after deductible
Mail-Order Generic		
• Preventive	$0 (no deductible)	Not covered
• Non-Preventive	80% after deductible	Not covered
Mail-Order Formulary Brand		
• Preventive	$0 (no deductible)	Not covered
• Non-Preventive	80% after deductible	Not covered
Mail-Order Non-Formulary Brand		
• Preventive	$100 copay (no deductible)	Not covered
• Non-Preventive	80% after deductible	Not covered

Finding a Participating Pharmacy

Locate participating pharmacies online at www.caremark.com or by calling CVS/caremark at 844-214-2607. If you are a new member to the CVS/caremark Pharmacy Plan, you will receive a new member packet.

Using the Mail-Order Pharmacy Benefit

If you are taking medication on a regular or long-term basis (90 days or longer) to treat an ongoing health condition, you are encouraged to use the mail-order pharmacy. When you use the mail-order pharmacy, you save money because you receive a 90-day supply of medication for the cost of two copayments (compared to three copayments if purchased through a participating retail pharmacy).

How to Get Started with the Mail-Order Benefit

To use your mail-order benefit:

- Ask your doctor to write two prescriptions — one for an initial 30-day supply that you can fill at your local pharmacy, and one for a 90-day supply, with appropriate refills up to one year.
- Complete the member profile form that you received with your CVS/caremark new member packet (you only need to complete the profile the first time you use the mail-order service). Be sure to include your member ID number, appropriate copayment and your prescription in the mailer envelope. You can also obtain a profile form online at www.caremark.com or by calling CVS/caremark at 844-214-2607.
- Mail your prescription and member profile form to CVS/caremark (the address is on the form).

Your first mail order prescription will be delivered to you within five days after the order is processed. Mail-order shipping is free.

Refilling Your Mail-Order Prescriptions

You must re-order your prescriptions by phone, mail or on the website every 90 days to continue receiving the medication. Subsequent mail orders take approximately seven days from the date you place the order until you receive the medication. You should order your next prescription 30 days before your current supply runs out to allow sufficient time for your request to be filled and shipped.

You may order refills:

- Online — go to the member website at www.caremark.com
- By phone — call 844-214-2607. Have your member ID number, your refill slip with the prescription number and your credit card ready
- By mail — use the refill and order forms provided with your medication. The address is on the form.

Paying for Your Mail-Order Medication

You may pay for your mail-order prescriptions by check, money order or credit card. If you send the wrong copayment amount and there is a balance due, an invoice will be included with your prescription order. If you overpay, your account will be credited.

How to Use the Retail Pharmacy Benefit

When you need to have a prescription filled on a short-term basis (typically for up to a 30-day supply), present your CVS/caremark member ID card to any CVS/caremark participating pharmacy. The pharmacy's computerized system will confirm your eligibility for benefits. If the prescription is covered, the pharmacist will fill your prescription and charge you the applicable copayment. You do not have to fill out a claim form when you fill your prescription at a participating pharmacy.

If you are in the Aetna Choice POS II with HSA and you fill your prescription at a non-participating pharmacy, you will have to pay for the prescription up front and send a claim form to CVS/caremark for reimbursement.

CVS/caremark Website

www.caremark.com

CVS/caremark maintains a personalized and secure website that provides you with instant access to your complete pharmacy benefit information, available whenever you need it. Access is quick and easy. Just go to the above website, click the "Register Now" link in the "Member Sign In" section and follow the online instructions to register and create your personal user name and password. You can access the following information on this website:

- **Your Pharmacy Benefits** — Overview of your pharmacy benefits and coverage, including formulary lookup and pharmacy locator tools
- **Prescription Price Check** — Helpful information about costs and savings opportunities for prescription medications
- **Your Prescription History** — Your personal record of prescription claims history with CVS/caremark
- **Online Prescription Ordering** — Mail-order prescriptions online and prescription refills every 90 days with free delivery to your home address. Also lets you check the status of your order and request forms for new and transferred prescriptions
- **Drug and Health Information** — Information on potential drug interactions, side effects, symptoms, risk factors, drug comparisons and treatment options
- **Online Customer Service** — Online access to a customer service team 24 hours a day, seven days a week.

Questions About CVS/caremark Benefits

CVS/caremark has a nationwide, toll-free telephone number you can call 24 hours a day, 365 days a year with questions about your prescription drug benefits. Call 844-214-2607 to:

- Ask questions about eligibility
- Find out if a particular prescription drug is covered under your plan
- Find out the status of a mail-order claim.

Preventive Care Medications

If you are enrolled in the Aetna Choice POS II with HSA, CVS/caremark covers a broad range of generic and formulary brand preventive prescription drugs at 100%, at no out-of-pocket cost to you. Non-formulary brand preventive drugs are $50 for a 30-day supply with no deductible. The types of preventive drugs covered at 100% include medication for high blood pressure, cholesterol, bone density, anticoagulants, vaccines, antiviral treatment, prenatal vitamins, diabetes, breast cancer prevention and asthma. For the most current list of preventive prescription drugs covered at 100%, visit the HealthySteps website at www.HealthySteps4u.org.

Generic Drugs

After a brand-name drug patent expires, other drug manufacturers may begin selling the drug under its chemical or “generic” name. Generally, generic drugs cost less because they do not require the same level of sales, marketing research and development expenses associated with brand-name drugs.

Formulary Drugs

CVS/caremark maintains a drug “formulary,” which is a comprehensive list of commonly prescribed brand-name and generic drugs selected by CVS/caremark for safety, clinical effectiveness and cost. You may view the formulary online at www.caremark.com. The website allows you to enter the name of your medication and learn whether or not it is on the formulary. If the medication is not on the formulary, the website will list alternative drugs that are available.

Your prescription cost will be higher if your physician does not prescribe a formulary drug. Sometimes your physician may prescribe a medication for which a brand-name or generic alternative drug is available. In such cases, your physician may specify that the prescription be dispensed as written (DAW). The pharmacist may then ask your physician whether an alternative drug may be appropriate for you. If so, your prescription will be filled with the alternative drug and a confirmation will be sent to you and your physician explaining the change. Note that your physician always makes the final decision on your medication and you can always choose to keep the original prescriptions. Pharmacies will only dispense the medication authorized by your physician.

Specialty Injectable Drugs — CVS/specialty

Specialty injectable drugs are drugs that must be injected (rather than swallowed or applied topically) to be effective. These are high-cost biotech drugs that are used to treat chronic diseases such as:

- Growth hormone disorders
- Hemophilia, von Willebrand disease and related bleeding disorders
- Hepatitis C
- Immune deficiencies
- Infertility

- Multiple sclerosis
- Osteo and rheumatoid arthritis.

Drugs such as insulin, vitamin B-12, epinephrine and glucagon are not considered specialty injectables and will be covered under the retail or mail-order plan. Any prescription drug excluded from coverage is also excluded as an injectable.

Injectable drugs that can be self-administered (injected subcutaneously), administered intravenously (directly into a vein) or intramuscularly (directly into a muscle) are dispensed under the prescription drug plan and must be purchased at the CVS/specialty mail-order pharmacy or through a contract CVS/specialty retail pharmacy only. These drugs can also be covered under your medical plan benefits if administered by a physician in the physician's office. Please note that specialty medications are limited to a 30-day supply — they are not available in 90-day supplies.

Please call CVS/specialty at 800-237-2767 with any questions or clarifications regarding a specific injectable drug's category, coverage or benefit.

Prior Authorization

Certain drugs require "prior authorization" from CVS/caremark before they can be covered. Prior authorization is the process by which requests for these drugs are reviewed against objective clinical criteria to determine whether coverage will be provided. Some products, such as those that are used for cosmetic purposes, are specifically excluded from coverage. If the medication you are trying to fill has a prior authorization requirement under the plan, the pharmacist will inform you of this. To request a prior authorization, your physician provides information to CVS/caremark's prior authorization unit. To do this, they must call in the required information to a special toll-free phone number or send the information by fax. The phone number and fax can be obtained by calling CVS/caremark's toll-free customer service number at 844-214-2607. Response to a physician's prior authorization request can take from one to two business days. Both the patient and physician will be notified in writing when the review process is completed. If your medication is approved for coverage, an automatic authorization will be entered in the system to allow your pharmacist to fill your prescription for your regular plan copayment. If your medication is not approved for coverage, you will have to pay the full cost of the drug.

Your doctor can ask for reconsideration of a prior authorization denial by submitting further information to the prior authorization unit. If reconsideration for the coverage is denied, you may file an appeal with CVS/caremark for further consideration of coverage.

The following are some of the drugs that require prior authorization under the prescription drug plan, although this list is not all-inclusive:

- Tretinoin such as Retin-A, if patient is over age 45
- Enbrel
- Lamisil

- Provigil
- Prescription drugs that exceed plan level limits. See “Quantity Level Limits” following this section for more information.

This list can change without prior notice. Please call CVS/caremark if you have any questions.

Quantity Level Limits

In most cases, when you fill a prescription you will receive the prescribed amount, up to a 30-day supply from the retail pharmacy, or a 90-day supply from the mail-order pharmacy. Certain drugs are limited, however, to a set quantity, regardless of what your physician prescribes. If the quantity requested is greater than plan level limits, the following are some of the drugs that require prior authorization, although this list is not all-inclusive:

- Injectable and non-injectable impotence medications (such as Viagra, Muse, Cialis, Caverject and Edex)
- Imitrex nasal spray

This list can change without prior notice. Please call CVS/caremark if you have questions about coverage and/or quantity limits for a specific prescription drug.

Step Therapy

There are certain prescription drugs subject to step therapy. Step therapy is a program especially for people who take prescription drugs regularly for an ongoing condition like arthritis, asthma or high blood pressure. This program applies edits to drugs in specific therapeutic classes at the point of service to guide patients into using more cost-effective, first-line alternatives when medically appropriate. Coverage for second-line therapies is determined at the patient level based on the presence or absence of first-line drugs in the patient’s claims history. This allows you and your family to receive the treatment you need while making prescription drugs more affordable for you and also helps our organization provide quality prescription drug benefits. The program moves you along a well-planned path or series of steps. Your doctor is consulted, approving and writing your prescriptions based on the step therapy drugs covered by our plan. The list of drugs subject to step therapy can change without prior notice.

What Drugs Are in the Step Therapy Program?

- Generic drugs are usually in the first step. Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics provided by the plan are effective for treating many medical conditions. Generics have the same chemical makeup and the same effect in the body as the original brand-name drug. They usually have a different name, color and/or shape. The companies that make generic drugs do not spend a great deal of money on research and advertising. That means the savings are passed on to you in the form of a lower copayment. This first step lets you begin or continue treatment with prescription drugs that have the lowest copayment.

- Brand-name drugs are usually in the second step. If your path requires more medications, then the program moves you along to this step. Brand-name drugs are usually more expensive than generics, so most have a higher copayment.

How Does Step Therapy Work?

- When you submit a prescription that is not for a first-step drug, your pharmacist will tell you that the plan uses step therapy. If you would rather not pay the full price for the drug, you or your pharmacist should contact your doctor. Only your doctor can approve and change your prescription to a first-step drug. Call CVS/caremark to get some examples of safe, effective first-step drugs to discuss with your doctor.

- More expensive brand-name drugs are covered in a later step. That is, if you have already tried the first-step drugs provided by your program, or your doctor decides you need a different drug for medical reasons, then your doctor can call CVS/caremark to request a prior authorization. A CVS/caremark representative will check your plan's guidelines to see if a second-step drug can be covered. If it can, you could pay a higher copayment than for a first-step drug. If it cannot be covered, you may need to pay the full price for the drug.

Drugs Not Covered

The following drugs are specifically not covered under the prescription drug plan:

- Agents used to suppress appetite and control fat absorption (including Xenica and Meridia)
- Depigmentation products used for skin conditions requiring a bleaching agent
- Drugs not specifically listed as a benefit
- Durable medical equipment (including respiratory therapy supplies, peak-flow meters, non-insulin syringes and ostomy supplies)
- Growth hormones
- Hair growth agents (including Propecia and Vaniqa)
- Injectables except insulin (including Aranesp, Epogen/Procrit, Botox, Prolastin, Forteo, Amevive, Remicade and Xolair, all allergens)
- Injectable cosmetics (including Botox cosmetic)
- Implants (including Norplant)
- IUDs
- Lancet devices
- Legend homeopathic drugs

- Photo-aged skin products (including Renova and Avage)
- Prescription vitamins, except prenatal agents used in pregnancy and therapeutic agents used for specific deficiencies and conditions
- Serums, toxoids and vaccines
- Yohimbine (for impotence).

To determine what medications are covered under the pharmacy plan, the CVS/caremark member website can be utilized to run a “Price/Coverage Check.” This tool processes test claims and, if covered, will return the current price based on the pharmacy plan benefits that are in place at the time of the check.

In addition, if there are lower cost alternatives (lower cost brand-name or generics) those products will be offered and priced on the results screen. To use this tool, visit caremark.com.

SHCA

Your prescription drug benefits are administered by Aetna. You do not need to enroll to participate in the Aetna prescription benefit; enrollment is automatic when you enroll in the SHCA. Prescription drugs may only be filled at an Aetna-affiliated pharmacy.

Aetna

If you are enrolled in the SHCA, you can fill short-term prescriptions at retail pharmacies and long-term prescriptions through the Aetna mail-order program.

The amount you pay per prescription depends on whether the drug is generic, formulary or non-formulary and whether you use a participating or non-participating pharmacy. You receive the highest benefit level when you use the mail-order service.

Prescription Drug Copays

Medication Type (Preventive and Non-Preventive)	SHCA
Retail Generic	$10 copay
Retail Formulary Brand	$25 copay
Retail Non-Formulary Brand	$50 copay
Mail Order Generic	$20 copay
Mail Order Formulary Brand	$50 copay
Mail Order Non-Formulary Brand	$100 copay

Finding a Participating Pharmacy

Locate participating pharmacies online at www.aetna.com. If you are a new member to the Aetna Pharmacy Plan, you will receive a new member packet.

Using the Mail-Order Pharmacy Benefit

If you are taking medication on a regular or long-term basis (90 days or longer) to treat an ongoing health condition, you are encouraged to use the mail-order pharmacy. When you use the mail-order pharmacy, you save money because you receive a 90-day supply of medication for the cost of two copayments (compared to three copayments if purchased through a participating retail pharmacy).

How to Get Started with the Mail-Order Benefit

To use your mail-order benefit:

- Ask your doctor to write two prescriptions — one for an initial 30-day supply that you can fill at your local pharmacy, and one for a 90-day supply, with appropriate refills up to one year
- Complete the member profile form that you received with your Aetna new member packet (you only need to complete the profile the first time you use the mail-order service). Be sure to include your member ID number, appropriate copayment and your prescription in the mailer envelope. You can also obtain a profile form online at www.aetna.com or by calling Aetna at 888-277-4041.
- Mail your prescription and member profile form to Aetna (the address is on the form).

Your first mail order will be delivered to you within 21 days. Mail-order shipping is free.

Refilling Your Mail-Order Prescriptions

You must re-order your prescriptions by phone, mail or on the website every 90 days to continue receiving the medication. Subsequent mail orders take approximately seven days from the date you place the order until you receive the medication. You should order your next prescription 30 days before your current supply runs out to allow sufficient time for your request to be filled and shipped.

You may order refills:

- Online — go to the member website at www.aetna.com
- By phone — call 888-277-4041. Have your member ID number, your refill slip with the prescription number and your credit card ready
- By mail — use the refill and order forms provided with your medication. The address is on the form.

Paying for Your Mail-Order Medication

You may pay for your mail-order prescriptions by check, money order or credit card. If you send the wrong copayment amount and there is a balance due, an invoice will be included with your prescription order. If you overpay, your account will be credited.

How to Use the Retail Pharmacy Benefit

When you need to have a prescription filled on a short-term basis (typically for up to a 30-day supply), present your Aetna member ID card to any Aetna-participating pharmacy. The pharmacy's computerized system will confirm your eligibility for benefits. If the prescription is covered, the pharmacist will fill your prescription and charge you the applicable copayment. You do not have to fill out a claim form when you fill your prescription at a participating pharmacy.

If you are in the SHCA and you fill your prescription at a non-participating pharmacy, you will pay the full cost for the prescription. Claims from a non-participating pharmacy are not covered by the plan.

Aetna Website

www.aetna.com

Aetna maintains a personalized and secure website that provides you with instant access to your complete pharmacy benefit information, available whenever you need it. Access is quick and easy. Just go to the website, click the link for members and follow the online instructions to register and create your personal user name and password. You can access the following information on this website:

- **Your Pharmacy Benefits** — Overview of your pharmacy benefits and coverage, including formulary lookup and pharmacy locator tools
- **Prescription Price Check** — Helpful information about costs and savings opportunities for prescription medications
- **Your Prescription History** — Your personal record of prescription claims history with Aetna
- **Online Prescription Ordering** — Mail-order prescriptions online and prescription refills every 90 days with free delivery to your home address. Also lets you check the status of your order and request forms for new and transferred prescriptions
- **Drug and Health Information** — Information on potential drug interactions, side effects, symptoms, risk factors, drug comparisons and treatment options
- **Online Customer Service** — Online access to a customer service team 24 hours a day, seven days a week.

Questions About Aetna Benefits

Aetna has a nationwide, toll-free telephone number you can call 24 hours a day, 365 days a year with questions about your prescription drug benefits. Call 888-277-4041 to:

- Ask questions about eligibility
- Find out if a particular prescription drug is covered under your plan
- Find out the status of a mail-order claim.

Generic Drugs

After a brand-name drug patent expires, other drug manufacturers may begin selling the drug under its chemical or "generic" name. Generally, generic drugs cost less because they do not require the same level of sales, marketing research and development expenses associated with brand-name drugs.

Formulary Drugs

Aetna maintains a drug "formulary," which is a comprehensive list of commonly prescribed brand-name and generic drugs selected by Aetna for safety, clinical effectiveness and cost. The formulary list will be included in your new member ID card packet. You may also view the formulary online at https://fm.formularynavigator.com/MemberPages/pdf/2017AetnaPremierPlusThreeTierOpenFormulary_9839_Full_0.pdf.

The website allows you to enter the name of your medication and learn whether or not it is on the formulary. If the medication is not on the formulary, the website will list alternative drugs that are available.

Your prescription cost will be higher if your physician does not prescribe a formulary drug. Sometimes your physician may prescribe a medication for which a brand-name or generic alternative drug is available. In such cases, your physician may specify that the prescription be dispensed as written (DAW). The pharmacist may then ask your physician whether an alternative drug may be appropriate for you. If so, your prescription will be filled with the alternative drug and a confirmation will be sent to you and your physician explaining the change. Note that your physician always makes the final decision on your medication and you can always choose to keep the original prescriptions. Pharmacies will only dispense the medication authorized by your physician.

Specialty Injectable Drugs — Aetna Specialty Pharmacy

Specialty injectable drugs are drugs that must be injected (rather than swallowed or applied topically) to be effective. These are high-cost biotech drugs that are used to treat chronic diseases such as:

- Growth hormone disorders
- Hemophilia, von Willebrand disease, and related bleeding disorders
- Hepatitis C
- Immune deficiencies
- Infertility
- Multiple sclerosis
- Osteo and rheumatoid arthritis.

Drugs such as insulin, vitamin B-12, epinephrine and glucagon are not considered specialty injectables and will be covered under the retail or mail-order plan. Any prescription drug excluded from coverage is also excluded as an injectable.

Injectable drugs that can be self-administered (injected subcutaneously), administered intravenously (directly into a vein), or intramuscularly (directly into a muscle) are dispensed under the prescription drug plan and must be purchased at the Aetna Specialty Pharmacy mail-order pharmacy or through a contract Aetna Specialty Pharmacy retail pharmacy only. These drugs can also be covered under your medical plan benefits if administered by a physician in the physician's office. Please note that specialty medications are limited to a 30-day supply — they are not available in 90-day supplies.

Please call Aetna Specialty Pharmacy at 888-277-4041 with any questions or clarifications regarding a specific injectable drug's category, coverage or benefit.

Prior Authorization

Certain drugs require "prior authorization" from Aetna before they can be covered. Prior authorization is the process by which requests for these drugs are reviewed against objective clinical criteria to determine whether coverage will be provided. Some products, such as those that are used for cosmetic purposes, are specifically excluded from coverage. If the medication you are trying to fill has a prior authorization requirement under the plan, the pharmacist will inform you of this.

To request a prior authorization, your physician provides information to Aetna's prior authorization unit. To do this, they must call in the required information to a special toll-free phone number or send the information by fax. The phone number and fax can be obtained by calling Aetna's toll-free Customer Service number at 888-277-4041. Response to a physician's prior authorization request can take from one to two business days. Both the patient and physician will be notified in writing when the review process is completed. If your medication is approved for coverage, an automatic authorization will be entered in the system to allow your pharmacist to fill your prescription for your regular plan copayment. If your medication is not approved for coverage, you will have to pay the full cost of the drug.

Your doctor can ask for reconsideration of a prior authorization denial by submitting further information to the prior authorization unit. If reconsideration for the coverage is denied, you may file an appeal with Aetna for further consideration of coverage.

The following drugs require prior authorization under the prescription drug plan, although this list is not all-inclusive:

- Tretinoin such as Retin-A, if patient is over age 36
- Enbrel
- Lamisil

- Provigil
- Prescription drugs that exceed plan level limits. See “Quantity Level Limits” in the below section for more information.

This list can change without prior notice. Please call Aetna if you have any questions.

Quantity Level Limits

In most cases, when you fill a prescription you will receive the prescribed amount, up to a 30-day supply from the retail pharmacy, or a 90-day supply from the mail-order pharmacy. Certain drugs are limited, however, to a set quantity, regardless of what your physician prescribes. If quantity requested is greater than plan level limits, the following drugs require prior authorization, although this list is not all-inclusive:

- Injectable and non-injectable impotence medications (such as Viagra, Muse, Cialis, Caverject and Edex)
- Imitrex nasal spray
- Stadol nasal spray.

This list can change without prior notice. Please call Aetna if you have questions about coverage and/or quantity limits for a specific prescription drug.

Step Therapy

There are certain prescription drugs subject to step therapy. Step therapy is a program especially for people who take prescription drugs regularly for an ongoing condition like arthritis, asthma or high blood pressure. This program applies edits to drugs in specific therapeutic classes at the point of service to guide patients into using more cost-effective, first-line alternatives when medically appropriate. Coverage for second-line therapies is determined at the patient level based on the presence or absence of first-line drugs in the patient’s claims history. This allows you and your family to receive the treatment you need while making prescription drugs more affordable for you and also helps our organization provide quality prescription drug benefits. The program moves you along a well-planned path or series of steps. Your doctor is consulted, approving and writing your prescriptions based on the step therapy drugs covered by our plan. The list of drugs subject to step therapy can change without prior notice.

What Drugs Are in the Step Therapy Program?

- Generic drugs are usually in the first step. Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics provided by the plan are effective for treating many medical conditions. Generics have the same chemical makeup and the same effect in the body as the original brand-name drug. They usually have a different name, color and/or shape. The companies that make generic drugs do not spend a great deal of money on research and advertising. That means the savings are passed on to you in the form of a lower copayment. This first step lets you begin or continue treatment with prescription drugs that have the lowest copayment.

- Brand-name drugs are usually in the second step. If your path requires more medications, then the program moves you along to this step. Brand-name drugs are usually more expensive than generics, so most have a higher copayment.

How Does Step Therapy Work?

- When you submit a prescription that is not for a first-step drug, your pharmacist will tell you that the plan uses step therapy. If you would rather not pay the full price for the drug, you or your pharmacist should contact your doctor. Only your doctor can approve and change your prescription to a first-step drug. Call Aetna to get some examples of safe, effective first-step drugs to discuss with your doctor.

- More expensive brand-name drugs are covered in a later step. That is, if you have already tried the first-step drugs provided by your program, or your doctor decides you need a different drug for medical reasons, then your doctor can call Aetna to request a prior authorization. An Aetna representative will check your plan's guidelines to see if a second-step drug can be covered. If it can, you could pay a higher copayment than for a first-step drug. If it cannot be covered, you may need to pay the full price for the drug.

Drugs Not Covered

The following drugs are specifically not covered under the prescription drug plan:

- Agents used to suppress appetite and control fat absorption (including Xenica and Meridia)
- Depigmentation products used for skin conditions requiring a bleaching agent
- Drugs not specifically listed as a benefit
- Durable medical equipment (including respiratory therapy supplies, peak-flow meters, non-insulin syringes and ostomy supplies)
- Growth hormones
- Hair growth agents (including Propecia and Vaniqa)
- Injectables except insulin (including Aranesp, Epogen/Procrit, Botox, Prolastin, Forteo, Amevive, Remicade and Xolair, all allergens)
- Injectable cosmetics (including Botox cosmetic)
- Implants (including Norplant)
- IUDs
- Lancet devices
- Legend homeopathic drugs
- Photo-aged skin products (including Renova and Avage)

- Prescription vitamins, except prenatal agents used in pregnancy and therapeutic agents used for specific deficiencies and conditions
- Serums, toxoids and vaccines
- Yohimbine (for impotence).

To determine what medications are covered under the pharmacy plan, the Aetna member website can be utilized to run a "Price/Coverage Check." This tool processes test claims and, if covered, will return the current price based on the pharmacy plan benefits that are in place at the time of the check.

In addition, if there are lower cost alternatives (lower cost brand name or generics) those products will be offered and priced on the results screen. To use this tool, visit www.aetnanavigator.com.

Kaiser Permanente HMO

If you are enrolled in the Kaiser Permanente HMO plan, your prescription drug coverage will be through Kaiser Permanente. Kaiser Permanente HMO plan participants should refer to their Evidence of Coverage Booklet for more information about their prescription drug coverage.

HealthySteps to Wellness

To help you improve and maintain your health and well-being — personally, financially and in the workplace — we offer HealthySteps to Wellness, a program available to employees enrolled in the hospitals' medical plans. Through the program, you have access to a variety of resources and tools to help you take a step in the direction of better health.

For more information about HealthySteps to Wellness, visit http://wellness.healthysteps4u.org.

Employee Assistance Program

In addition to mental health and substance abuse benefits provided in your medical plan, the hospitals offer confidential and free counseling services to help you and members of your household with work-related, marital, family and personal issues. Receive up to 10 visits per incident per calendar year. A licensed professional is available to help you with issues such as stress, depression, substance abuse, grief/loss, interpersonal relationships and transitions in the workplace, as well as financial and legal matters. To obtain more information or to make an appointment, call Beacon Health Options at the number provided at the end of the *Administrative Information* section.

Dental Plan

Your Dental Plan Choices

The hospitals offer dental coverage through Delta Dental. You may choose from these options:

- Delta Dental Basic PPO — a managed fee-for-service plan;

- Delta Dental Buy-Up PPO — a managed fee-for-service plan that offers greater coverage than the Delta Dental Basic PPO; or
- DeltaCare® USA — a DHMO plan.

To receive dental coverage, you must enroll in one of the dental plans. See the *Using Your Handbook and Benefits Program* section for information about dependents you may cover under the dental plans.

Comparison of Dental Plans

	Delta Dental Basic PPO	Delta Dental Buy-Up PPO	DeltaCare USA DHMO
Choice of Dentists	Any licensed dentist; however, if you use dentists who have not agreed to Delta Dental's negotiated fee, you have higher out-of-pocket costs	Any licensed dentist; however, if you use dentists who have not agreed to Delta Dental's negotiated fee, you have higher out-of-pocket costs	Any dentist in the DeltaCare USA network. See the DeltaCare USA network directory for a list of dental offices
Eligible Expense	Treatment and services that are: • Prescribed by a licensed dentist, and • Covered by the plan	Treatment and services that are: • Prescribed by a licensed dentist, and • Covered by the plan	Treatment and services that are prescribed and authorized by your DeltaCare USA dentist
Calendar-Year Deductible	$50/enrolled person but no more than $150/family	$25/enrolled person but no more than $75/family	None
Diagnostic and Preventive Care (includes routine exams, cleanings and X-rays)	• Plan pays 100% of Delta Dental's negotiated fee • No deductible	• Plan pays 100% of Delta Dental's negotiated fee • No deductible	• No cost for most services
Basic and Restorative Care (includes fillings, oral surgery, routine root canal, gum surgery and night guards (with limitations))	Plan pays 80% of Delta Dental's negotiated fee after you pay the deductible	Plan pays 90% of Delta Dental's negotiated fee after you pay the deductible	• Some services are covered at no cost and others require a copayment, which varies by procedure; see your DeltaCare USA Evidence of Coverage Booklet
Major Care (includes reconstructive	Plan pays 50% of Delta Dental's negotiated fee after	Plan pays 60% of Delta Dental's negotiated fee after	Some services are covered at no cost and others require a

	Delta Dental Basic PPO	Delta Dental Buy-Up PPO	DeltaCare USA DHMO
procedures such as crowns, bridges and dentures)	you pay the deductible	you pay the deductible	copayment which varies by procedure; see your DeltaCare USA Evidence of Coverage Booklet
Orthodontia	• Plan pays 50% of Delta Dental's negotiated fee • No deductible • Maximum lifetime benefit per eligible adult or child is $1,500 • Covers children and adults	• Plan pays 50% of Delta Dental's negotiated fee • No deductible • Maximum lifetime benefit per eligible adult or child is $2,000 • Covers children and adults	You pay: • $350 start-up fee • $1,600 for children under age 19 • $1,800 for adults or children up to age 26
Calendar-Year Maximum Benefit	• $2,000 per covered person	• $2,500 per covered person	None, except for accidental injury
Claim Forms	Participating dentists will file the claim for you	Participating dentists will file the claim for you	None
Predetermination Request	Recommended for treatment costing more than $300	Recommended for treatment costing more than $300	Your DeltaCare USA dentist obtains approval for specialty treatment

Services Not Covered by the Plans

The following expenses are excluded from the Delta Dental Basic PPO, Delta Dental Buy-Up PPO and DeltaCare USA DHMO Plans:

- Experimental procedures
- Prescription drugs
- Charges for services/treatment performed in a hospital or other surgical or treatment facility and any additional fees charged for treatment in such facility
- Services for injuries covered by workers' compensation or employer's liability laws or services which are paid by any federal, state or local government agency
- Services for cosmetic purposes, or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel

- Expenses incurred for treatment started before you are covered by the plan or after termination of coverage – except as otherwise provided
- Services or items not specifically listed as a benefit.

If You Are Covered by Another Plan

You may decide to waive the hospitals' dental coverage if you have coverage under another employer's plan. See "Order of Benefit Determination Rules" on page 78 for more information. If you and your spouse/eligible domestic partner both work for the hospitals, see the *Using Your Handbook and Benefits Program* section.

The DeltaCare USA DHMO plan coordinates benefits for authorized treatment given by a specialist or out-of-network dentist. However, benefits for treatment received by a network dentist are provided without regard to other plan coverage.

Using Your Plan — Delta Dental Basic or Buy-Up PPO

How the Plans Work

Maximum Calendar-Year Benefit

The maximum calendar-year benefit under the Delta Dental Basic PPO is $2,000 for each covered person. The maximum calendar-year benefit under the Delta Dental Buy-Up PPO is $2,500 for each covered person.

Predetermination Request

If you need treatment other than extraction, fillings or routine preventive care, or if your treatment is likely to cost more than $300, ask your dentist to submit a written treatment plan to Delta Dental — before scheduling treatment. Delta Dental will let you know if you are eligible for benefits and the amount of the benefit to which you are entitled. If you do not obtain predetermination, you run the risk of being responsible for a larger portion of the fees.

In the Delta Dental Basic or Buy-Up PPO, you may use any licensed dentist. However, if you use dentists who have not agreed to Delta Dental's negotiated fee, you will have higher out-of-pocket costs. Reimbursement is based on PPO contracted fees for PPO dentists, premier contracted fees for premier dentists and program allowance for non-Delta Dental dentists. See the Delta Dental Basic or Buy-Up PPO network directory for a list of participating providers.

What's Covered

Diagnostics and Preventive Care

Diagnostic and preventive care is covered at 100% of Delta Dental's negotiated fees and includes the following:

- Routine exams — up to two per calendar year
- X-rays — bitewing limited to two per calendar year up to age 18 and one per calendar year over age 18; full-mouth limited to one every five years

- Diagnostic casts — when part of orthodontic treatment
- Prophylaxis (cleaning) — limited to two per calendar year including cleaning as part of periodontic treatment
- Emergency palliative treatment to relieve pain — including sedative fillings and X-rays
- Space maintainers
- Biopsy and exam of oral tissue
- Specialist consultation.

Basic and Restorative Care

After you pay the calendar-year deductible, the plan pays 80% of Delta Dental's negotiated fee for basic and restorative care in the Delta Dental Basic PPO or 90% of Delta Dental's negotiated fee for basic and restorative care in the Delta Dental Buy-Up PPO.

Basic and restorative care includes:

- Oral surgery — extractions and certain other surgical procedures, including pre-and post-operative care and general anesthesia when necessary
- Restorative (fillings) — amalgam, silicate, plastic or resin for treatment of tooth decay
- Periodontic (root canal therapy) — for treatment of gums and bones supporting the teeth
- Gum surgery — treatment for disease of the gums, limited to one quadrant every 24 months
- Sealants — if applied to prevent decay on first molars through age nine and second molars through age fifteen
- Night guards (intraoral removable appliances) — to treat harmful oral habits associated with periodontal diseases, limited to one device every 24 months.

Major Treatment

After you pay the deductible, the plan pays 50% of Delta Dental's negotiated fees for major treatment in the Delta Dental Basic PPO or 60% of Delta Dental's negotiated fee for major treatment in the Delta Dental Buy-Up PPO.

Major treatment includes:

- Reconstructive procedures, such as crowns, jackets, inlays, onlays and cast restorations to treat cavities that cannot be restored with regular fillings. Benefits for services on the same tooth are paid only once every five years.

- Construction or repair of fixed bridges, partial bridges and dentures if provided to replace missing natural teeth. Benefits for services on the same tooth are paid only once every five years.

Orthodontia

Orthodontia services are procedures using appliances or surgery to straighten or realign teeth which otherwise would not function properly.

The Delta Dental plan pays 50% of Delta Dental's negotiated fee for covered orthodontia services for adults and eligible dependent children as defined in the *Using Your Handbook and Benefits Program* section. The maximum lifetime benefit per person is $1,500 for the Delta Dental Basic PPO or $2,000 for the Delta Dental Buy-Up PPO. Other limitations include:

- The plan does not pay for treatment begun before your child becomes eligible for coverage.
- The plan stops payments when the first payment is due to the dentist either following a loss of eligibility for coverage or if treatment is ended for any reason before it is completed.
- X-rays and extractions that might be necessary for orthodontic treatment are not covered by the orthodontic benefit, but may be covered under diagnostic, preventive or basic benefits.

What's Not Covered

The following expenses are not covered by the Delta Dental plan:

- A more expensive plan of treatment than is customarily provided. Examples include:
  - A crown where a silver filling would restore the tooth
  - A gold crown where one made of semi-precious materials would restore the tooth
  - A precision denture where a standard denture would suffice.
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless:
  - The replacement is necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth
  - The bridge, crown or denture, while in the mouth, was damaged beyond repair as the result of an injury sustained while enrolled in the plan
  - Delta Dental determines that the replacement is required because the restoration is unsatisfactory as a result of poor quality of care or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

- Any replacement of a bridge, crown or denture that is or can be made usable according to common dental standards
- Treatments which restores tooth structure that is worn, rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion, stabilizes the teeth. Examples of such treatments are equilibration and periodontal splinting
- Any single procedure, bridge, denture or other prosthodontic service started before you were covered by the plan
- Grafting tissues from outside the mouth to tissue inside the mouth (“extra-oral grafts”)
- Services for any disturbances of the jaw joints (temporomandibular joints or “TMJ”) or associated muscles, nerves or tissues
- Orthodontic services, except those provided to eligible dependent children
- Charges for replacement or repair of an orthodontic appliance paid in part or in full by the plan
- X-rays and extractions that might be necessary for orthodontic treatment are not covered by orthodontic benefits, but may be covered under diagnostic and preventive or basic benefits
- Direct composite (resin) restorations on anterior teeth and the facial surface of bicuspids are covered. Any other posterior direct composite (resin) restorations are optional services and Delta Dental’s payment is limited to the cost of the equivalent amalgam restorations
- Sealant benefits are limited to the first molars up to age nine and second molars up to age fifteen. Permanent molars must be without decay or restorations and have the occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application
- Anesthesia except for general anesthesia given by a dentist for covered oral surgery procedures under the Delta Dental plan
- Services or items not specifically listed as a benefit.

After-Hours and Urgent Care

If you or a family member has special needs, you should ask your dentist about accessibility to their office or clinic at the time you call for an appointment. Your dentist will be able to tell you if their office is accessible, taking into consideration the specific requirements of your needs.

Urgent care may be obtained from any licensed dentist during their normal office hours. Delta Dental does not require prior authorization before seeking treatment for urgent or after-hours care. You may plan in advance for treatment for urgent, emergency or after-hours care by asking your dentist how you can contact the dentist in the event you or a family member may need urgent care treatment or treatment after normal business hours. Many dentists have made prior arrangements with other dentists to provide care to you if treatment is immediately or urgently needed. You may also call the local dental society that is listed in your local telephone directory if your dentist is not available to refer you to another dentist for urgent, emergency or after-hours care.

DeltaCare USA DHMO Plan

Delta Dental has established a network of dentists to provide care to members of the DeltaCare USA DHMO plan. To receive benefits under the DeltaCare USA DHMO plan, you must use one of the network dentists.

When you enroll, you must choose one of the network dentists for each covered dependent. If you do not choose a dentist, DeltaCare USA will select one for you.

After you enroll, you will receive a DeltaCare USA membership packet including the address and telephone number of your network dentist. Your dentist will coordinate dental care for you and all your covered dependents.

Please reference your Evidence of Coverage and Disclosure Booklet online. It fully describes your benefits under this plan. Please contact the HealthySteps benefits service center at 855-278-7157 for a paper copy to be mailed to you at no charge, or you can visit HealthySteps4u.org. Your Evidence of Coverage and Disclosure Booklet is an official part of this Handbook.

How to Use the DeltaCare USA DHMO Plan

When you need care, call your dentist. If you do not know who your dentist is, call DeltaCare USA at 800-422-4234. Your dentist will treat you for most basic services. For specialty care, your dentist will obtain written approval from DeltaCare USA before referring you to a network specialist.

You do not have to file a claim. You pay only the copayment that applies for the covered treatment.

Changing Dentists

You may change dentists at any time by calling DeltaCare USA. If you call by the 15th of the month, your change will be effective on the first day of the following month.

Vision Plan

What's Offered

When you enroll in one of the medical plans offered by the hospitals, you automatically receive vision coverage administered by VSP®. The dependents you enroll in your medical plan are also automatically enrolled in the vision plan.

Summary of Benefits

	When You Use a VSP-Participating Provider	When You Use a Non-VSP-Participating Provider
Availability and Choice of Doctors	Call your eye care professional to find out if he or she belongs to the VSP network	You may use any licensed provider
Eye Exam Every Calendar Year	Covered in full after $10 copay	Reimbursed up to $50 after $10 copay
Prescription Glasses (see below for specific lens and frames benefits)	$25 copay	$25 copay
Lenses Every Calendar Year	The following are covered in full every year: • Single vision, lined bifocal and lined trifocal and lenticular lenses • Polycarbonate lenses for dependent children Other lens types covered at an additional cost: • Standard progressive lenses: $40 • Premium progressive lenses: $40 • Custom progressive lenses: $40 • Anti-reflection coating: $40 • Average savings of 35% – 40% off other lens options	Reimbursed up to: • Single vision lenses: $50/pair • Lined bifocal lenses: $75/pair • Lined trifocal lenses: $100/pair • Lenticular lenses: $125/pair • Progressive lenses: $75/pair
Frames Every Other Calendar Year	Frame of your choice covered up to $150 (or up to $170 for featured frame brands).[6] Plus, 20% off any out-of-pocket costs	Reimbursed up to $70

	When You Use a VSP-Participating Provider	When You Use a Non-VSP-Participating Provider
Contacts Every Calendar Year	Reimbursed up to $150[7] toward the cost of the contact lens evaluation and fitting and the contacts	Reimbursed up to $105[7] toward the cost of the contact lens evaluation and fitting and the contacts
	Contact lens benefit would be used instead of lenses and frames. For example, you may purchase lenses or contacts every calendar year and frames every other calendar year. So, if you purchased contacts in 2016, frames would not be covered until the year 2018. If, instead, you purchased a pair of glasses in 2016 and contacts in 2017, frames would not be covered until the year 2019	
Low Vision Benefit – for severe vision problems not correctable with regular lenses; prior approval required	Eligible expenses for testing are covered in full. 75% of eligible expenses for supplemental aids are covered. Maximum combined benefit is $1,000 every two years	You pay your provider and then file a claim with VSP. VSP reimburses you up to $125 of eligible expenses. 75% of eligible expenses for supplemental aids are covered. Maximum combined benefit is $1,000 every two years
Laser Vision Correction	Discounted services available through contracted laser centers	None
Filing Claims	None	You pay the provider and request reimbursement from VSP

6 Your VSP-participating provider will show you frames that are covered in full by the plan. You may choose one of the provider's other frames and pay the difference based on VSP's preferred member pricing.

7 A 15% discount is available from VSP-participating providers and applies to the provider's usual and customary professional fees for contact lens evaluation and fitting.

In-Network Providers

VSP has an extensive nationwide network of providers who deliver quality eye care and eyewear. When you are ready to obtain vision care services, locate a VSP-participating provider by calling VSP at 800-877-7195 or by visiting VSP's website at www.vsp.com.

When you call to make an appointment, identify yourself as a VSP member and the name of your group number (see the *Administrative Information* section for details). The VSP-participating provider will contact VSP to verify your eligibility and plan coverage.

At your appointment, the participating provider will provide an eye exam and determine if glasses or contact lenses are needed.

VSP will pay the participating provider directly for covered services. When you visit a VSP-participating provider, you pay:

- $10 for the eye exam
- $25 for lenses and frames

- Additional costs for cosmetic options, costs exceeding the frame and contact lens allowance
- Any fees for non-covered services and eyewear.

Out-of-Network Providers

If you do not obtain services and/or eyewear from a VSP-participating provider, you must pay the full amount of the bill. To be reimbursed for eligible expenses, you must submit a claim to VSP and include a copy of the itemized bill within 12 months of the date of service.

You will be reimbursed based on the schedule beginning on page 62.

Your claim must include the following information:

- Name of the doctor or doctor's office
- Name of the patient
- Date of the service
- Itemized list of each service received and amount paid.

You can submit the claim online and attach your receipts, or you can print the completed claim form and mail it with your receipts to the VSP address shown at the end of the *Administrative Information* section.

Limits on Coverage

Because VSP is designed to help cover visual rather than cosmetic eyewear, you will be required to pay extra for the following items:

- Blended and oversize lenses
- Contact lenses, except as noted
- Progressive multifocal lenses, except as noted
- Cosmetic lenses
- Optional cosmetic processes
- Photochromic lenses; tinted lenses, except Pink 1 or 2
- Coated or laminated lenses
- Frames costing more than the plan limits
- Costs that exceed the low vision benefit
- UV protected lenses.

What's Not Covered

The following professional services or eyewear are not covered:

- Orthoptics or vision training, and any associated supplemental testing
- Plano lenses (non-prescription)
- Two pair of glasses in lieu of lined bifocals
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision services, treatments and eyewear of an experimental nature
- Items or services that are not specifically listed as a benefit.

Extra Discounts and Savings

When visiting VSP-participating providers, VSP offers a 30% discount on additional glasses and sunglasses, including lens options from the same VSP-participating provider on the same day as your WellVision Exam®. Or you can get a 20% discount on additional glasses from any VSP-participating provider within 12 months of your last WellVision Exam®. A 15% discount is offered on the cost of the contact lens exam (fitting and evaluation) when you purchase prescription contacts. In addition, you will also receive between 35% – 40% off all non-covered lens options, such as scratch resistant and photochromic lenses.

VSP has arranged for members to receive PRK, LASIK and Custom LASIK at a discounted fee, which could add up to hundreds of dollars in savings. The Laser Vision Care discount provides an average of 15% off the regular price or 5% off the promotional price. Discounts are available from contracted facilities.

Filing and Appealing Medical Claims

Filing a Medical Claim

This section applies to the Aetna Choice POS II with HSA and SHCA plans. For the Kaiser Permanente HMO plan, please refer to the Kaiser Permanente HMO Plan Evidence of Coverage Booklet for details.

Type of Claims and Definitions

- **Pre-service claim** needing prior authorization as required by the plan – This is a claim for a benefit where the covered person is required to get approval from the plan before obtaining the medical care such as in the case of prior authorization of health care items or service that the plan requires. If a covered person or provider calls the plan just to find out if a claim will be covered, that is not a pre-service claim, unless the plan and/or Aetna's Health Booklet specifically requires the person to call for prior authorization. Giving prior authorization does not guarantee that the plan will ultimately pay the claim

- **Post-service claim** means a claim that involves payment for the cost of health care that has already been provided

- **Concurrent care claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the plan.

Urgent or Emergency Claims

Note that these plans do not require prior authorization for urgent or emergency care claims; however, covered persons may be required to notify the plan following stabilization. Please refer to the "Claims, Appeals and External Review" section in Aetna's Health Booklet for more details. A condition is considered to be an urgent or emergency care situation when a sudden and serious condition such that a prudent layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her bodily functions would result unless immediate medical care was rendered. Examples of an urgent or emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity or a severe allergic reaction.

Personal Representative

Personal representative means a person (or provider) who can contact the plan on the covered person's behalf to help with claims, appeals or other benefit issues. Minor dependents must have the signature of a parent or legal guardian in order to appoint a third party as a personal representative.

If a covered person chooses to use a personal representative, the covered person must submit a written letter to the plan stating the following: the name of the personal representative, the date and duration of the appointment and any other pertinent information. In addition, the covered person must agree to grant their personal representative access to their Protected Health Information (PHI). This letter must be signed by the covered person to be considered official.

Procedures for Submitting Claims

Most providers will accept assignment and coordinate payment directly with the plan on the covered person's behalf. If the provider will not accept assignment or coordinate payment directly with the plan, then the covered person will need to send the claim to the plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health membership card.

Covered persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the plan, the covered person will need to pay the claim up front and then submit the claim to the plan for reimbursement. The plan will reimburse covered persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the covered person paid the claim or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered person/patient ID number, name, sex, date of birth, Social Security number, address and relationship to employee
- Authorized signature from the covered person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address and telephone number
- Provider Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)

- Whether the patient's condition is related to employment, auto accident or other accident (if applicable)
- Assignment of benefits (if applicable).

Timely Filing

Covered persons are responsible for ensuring that complete claims are submitted to the third party administrator as soon as possible after services are received, but no later than 12 months from the date of service. Where Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration hospital has six years from the date of service to submit the claim. A complete claim means that the plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

Adverse Benefit Determination (Denied Claims)

Adverse benefit determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the covered person is no longer eligible to participate in the plan.

If a claim is being denied in whole or in part, and the covered person will owe any amount to the provider, the covered person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial
- Provide a specific reference to pertinent plan provisions on which the denial was based
- Provide a description of any material or information that is necessary for the covered person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable
- Provide appropriate information as to the steps the covered person can take to submit the claim for appeal (review)
- If an internal rule or guideline was relied upon, or if the denial was based on medical necessity or experimental treatment, the plan will notify the covered person of that fact. The covered person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

Appeal Procedures for Adverse Benefit Determinations

Urgent/Expedited Appeal

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your ID card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and Aetna by telephone, fax or other similar method. You will be notified of the decision no later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision no later than 36 hours after the appeal is received.

First Level of Appeal

This is a **mandatory** appeal level. The covered person must exhaust the following internal procedures before any outside action is taken.

- Covered persons must file the appeal within 180 days of the date they received the EOB form from the plan showing that the claim was denied. The plan will assume that covered persons received the EOB form five days after the plan mailed the EOB form.
- Covered persons or their personal representative will be allowed reasonable access to review or copy pertinent documents at no charge.
- Covered persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time as the written request for a review.
- Covered persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the covered person’s request, regardless of whether the plan relies on their advice in making any benefit determinations.

- After the claim has been reviewed, covered persons will receive written notification letting them know if the claim is being approved or denied. The notification will provide covered persons with the information outlined under the adverse benefit determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this Handbook.

Second Level of Appeal

This is a **voluntary** appeal level. The covered person is not required to follow this internal procedure before taking outside legal action.

- Covered persons who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- Covered persons or their personal representative must submit a written request for a second review within 60 calendar days following the date they received the plan's decision regarding the first appeal.
- The plan will assume that covered persons received the determination letter regarding the first appeal five days following the date the plan sends the determination letter.
- Covered persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review.
- Covered persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the covered person's request, regardless of whether the plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the covered person will receive written notification letting them know if the claim is being approved or denied. The notification will provide the covered person with the information outlined under the adverse benefit determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this Handbook.

Your Rights and the Voluntary Appeal Process

The plan agrees that any legal limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process.

A covered person may only initiate the voluntary appeal process after completing a mandatory appeal. If a covered person elects a voluntary appeal, the plan agrees that it will not charge a fee for going through the voluntary appeal process. A covered person's decision to submit a benefit dispute claim through this voluntary appeal level will not have an effect on their rights to use other benefits under the plan.

Should the covered person pursue this voluntary appeal process in court, the plan cannot claim that the covered person did not try everything in his or her power to rectify the issue before starting the voluntary appeal process.

If you have questions about the voluntary level of appeal process, including:

- Applicable rules
- A covered person's right to representation (personal representative)
- Other details.

Please contact the Plan Administrator. Refer to "ERISA Statement of Rights" in the *Administrative Information* section for details on a covered person's additional rights to challenge the benefit decision under Section 502(a) of ERISA.

Sending in Your Appeal

Appeals should be sent within 60 calendar days following the date you received the plan's decision regarding the first level appeal.

This plan contracts with various companies to administer different parts of this plan. Covered persons who want to appeal a decision or a claim determination made by one of these companies should send appeals directly to the company that made the decision being appealed.

In this instance, send medical appeals to:

For the Aetna Choice POS II with HSA and SHCA plans:

Aetna
Attn: National Account CRT
P. O. Box 14463
Lexington, KY 40512

Time Periods for Making Decision on Appeals

After reviewing a claim that has been appealed, the plan will notify the covered person of its decision within the following timeframes:

- Urgent/expedited claim — Within 36 hours after the appeal is received
- Pre-service claim — Within a reasonable period of time appropriate to the medical circumstances but no later than 15 calendar days after the plan receives the request for review
- Post-service claim — Within a reasonable period of time but no later than 30 calendar days after the plan receives the request for review
- Concurrent care claims — Before treatment ends or is reduced.

Covered persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the plan will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Right to External Review

If you have utilized all of your internal appeal options, including a mandatory and voluntary appeal and you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- Clinical reasons;
- Exclusions for experimental or investigational services or unproven services; or
- Otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if Aetna or your employer fails to respond to your appeal within the timelines stated above.

You may request an independent review of the adverse benefit determination. Neither you nor Aetna or your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If your appeal is eligible and you wish to pursue an external review, you will be provided with a form and return address in the response to your final appeal.

Your written request should include: (1) Your specific request for an external review; (2) the employee's name, address and member ID number; (3) Your designated representative's name and address, if applicable; (4) the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time your request is received.

All requests for an independent review must be made within 123 calendar days of the date you receive the adverse benefit determination. You, your treating physician or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the plan. The Independent Review Organization (IRO) has been contracted by Aetna and has no material affiliation or interest with Aetna or your employer. Aetna will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of Aetna’s receipt of a request for independent review, the request will be forwarded to the IRO together with:

- All relevant medical records;
- All other documents relied upon by Aetna and/or your employer in making a decision on the case; and
- All other information or evidence that you or your physician has already submitted to Aetna or your employer.

If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and Aetna will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer’s decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and Aetna and/or your employer with the reviewer’s decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the plan. If the final independent review decision is that payment or referral will not be made, the plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

Filing a Claim or Appeal for Dental, Vision, Prescription or Mental Health Benefits

Filing a Dental Claim — Delta Dental Basic or Buy-Up PPO

To receive benefits for eligible dental expenses under the Delta Dental plans, you must file a claim form. Send your completed claim form to the address shown in the *Administrative Information* section. You must submit your claim within six months of the date you receive care. If you use a Delta Dental-participating dentist, he or she will file the claim for you. Also, Delta Dental pays participating dentists directly. You are only responsible for your share of the bill.

If you have questions about your claims or benefits, contact Delta Dental by phone or by visiting them online at www.deltadentalins.com.

Filing a Dental Appeal — Delta Dental Basic or Buy-Up PPO

If you have any questions about the services you receive, discuss the matter with your dentist. If you continue to have concerns, contact Delta Dental at 800-765-6003.

You may file a complaint with the Department of Managed Health Care at 888-466-2219 after you have been involved in Delta Dental's appeal process for 60 days. You may file a complaint with the Department of Managed Health Care immediately in an emergency situation involving imminent and serious threat to your health.

After you receive written notification that your claim has been denied, you have 60 days to submit an appeal. The appeal must contain:

- Your name, Social Security number and telephone number
- The patient's name
- The group name (the hospital)
- The treatment plan.

Generally, Delta Dental will respond to your appeal within 30 days. If more information is required, Delta Dental may take up to 120 days to respond. In the event of an imminent and serious threat to a patient's health, Delta Dental will respond within three days. For your rights under ERISA, see the *Administrative Information* section.

Filing a Dental Appeal — DeltaCare® USA DHMO Plan

If you have any questions about the services you receive, discuss the matter with your dentist. If you continue to have concerns, contact DeltaCare USA at 800-422-4234.

You may file a complaint with the Department of Managed Health Care at 888-466-2219 after you have been involved in the plan's appeal procedure for 30 days. You may file a complaint with the Department of Managed Health Care immediately in an emergency situation which is defined as one involving imminent and serious threat to your health.

See your Evidence of Coverage and Disclosure the *Administrative Information* section for information about the appeals procedure.

For your rights under ERISA, see the *Administrative Information* section.

Filing a Vision Appeal

If you have any questions about the services you receive, discuss the matter with your eye care specialist. If you continue to have concerns, contact VSP at 800-877-7195.

You may file a complaint with the Department of Managed Health Care at 800-466-2219 immediately in an emergency situation, which is defined as one involving imminent and serious threat to your health.

If a claim is denied, you may request a review by writing to VSP within 180 days of receipt of the denial notice. Include your name, Social Security number and the name and date of birth of the patient. You will be advised, in writing, of the final disposition of the claim.

For your rights under ERISA, see the *Administrative Information* section.

Filing a Pharmacy Claim or Appeal — Aetna

In some instances, you will be required to pay for your prescription and then submit a claim to Aetna. Should you have any questions regarding your pharmacy benefits and making a claim, contact Aetna at any time by calling 888-277-4041.

If you need to file an appeal, please contact Aetna at the address listed below:

Aetna
Attn: National Account CRT
P. O. Box 14463
Lexington, KY 40512

Filing a Pharmacy Claim or Appeal — CVS/caremark

In some instances, you will be required to pay for your prescription and then submit a claim to CVS/caremark. Should you have any questions regarding your pharmacy benefits and making a claim, contact CVS/caremark at any time by calling 844-214-2607.

If you need to file an appeal, please contact CVS/caremark at the address listed below:

CVS/caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

Filing a Mental Health Claim — United Behavioral Health (Operating Under the Brand Optum) for Aetna Choice POS II with HSA

If you wish to file a claim, please do so by sending the necessary documentation to:

UBH/Optum Claims
P.O. Box 30755
Salt Lake City UT 84130-0755
Telephone: 866-374-6060

Claims for out-of-network services should be submitted online through liveandworkwell.com, access code: bwell.

Your Rights to an Appeal

You, your treating provider or someone acting on your behalf has the right to request an appeal review of the decision made by United Behavioral Health (UBH). You may request an appeal either verbally or in writing by following the steps below.

You have the right to file an urgent or non-urgent appeal. An urgent appeal can be requested if a delay in treatment places your health or the health of others in serious jeopardy, significantly increases the risk to your health, results in severe pain or impacts your ability to regain maximum functioning.

If you have questions after reviewing the following information, please call 866-556-5166.

You may initiate your appeal in writing or verbally by contacting United Behavioral Health/Optum at the address or toll-free telephone number listed below.

Optum Behavioral Health
Attn: Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512
Telephone: 866-556-8166
Fax: 855-312-1470

Your appeal request should include the following:

- Your name and membership number from your ID card

- The date(s) of service(s)
- Your treating provider's name
- Any additional information you would like to be considered as part of the appeal process. Examples of such information are: records relating to the current conditions of treatment, co-existent conditions or any other relevant information.

For clinical cases, a board-certified physician in the same or similar specialty area as your treating physician will review and make the decision about your appeal request. If your treating provider is not a physician, a doctoral-level psychologist or a physician will review and make a decision about your appeal request. The Optum physician or psychologist will not have had any previous involvement in decisions about your case.

Coordination of Benefits

How Coordination of Benefits Works

Coordination of Benefits (COB) applies whenever a covered person has health coverage under more than one plan as defined below. The purpose of coordinating benefits is to help covered persons pay for covered expenses but not to result in total benefits that are greater than the covered expenses incurred.

The order of benefit determination rules determine which plan will pay first (primary plan). The primary plan pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays for covered expenses after the primary plan has processed the claim, and will reduce the benefits it pays so that the total payment between the primary plan and secondary plan does not exceed the covered expenses incurred. If the covered benefit under this plan is less than or equal to the primary plan's payment, then no payment is made by this plan.

The plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured
- Hospital indemnity benefits in excess of $200 per day
- Specified disease policies
- Foreign health care coverage
- Medical care components of group long-term care contracts such as skilled nursing care
- Medical benefits under group or individual motor vehicle policies. See "Order of Benefit Determination Rules" on page 78 for details
- Medical benefits under homeowner's insurance policies

- Medicare or other governmental benefits as permitted by law. See “Order of Benefit Determination Rules” on page 78. This does not include Medicaid.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the covered person for the difference between the provider’s contracted amount and the provider’s regular billed charge.

Order of Benefit Determination Rules

The first of the following rules that apply to a covered person’s situation is the rule to use:

- The plan that has no coordination of benefits provision is considered primary.
- When medical payments are available under motor vehicle insurance (including no-fault policies), this plan shall always be considered secondary regardless of the individual’s election under PIP (personal injury protection) coverage with the auto carrier.
- Where an individual is covered under one plan as a dependent and another plan as an employee, member or subscriber, the plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) is considered primary. The primary plan must pay benefits without regard to the possibility that another plan may cover some expenses. This plan will deem any employee plan beneficiary to be eligible for primary benefits from their employer’s benefit plan.
- The plan that covers a person as a dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent (see “COBRA Continuation of Coverage” on page 83). Also see “If You Are Covered by Medicare” on page 79 for exceptions.
- When an individual is covered under a spouse’s plan and also under his or her parent’s plan, the primary plan is the plan of the individual’s spouse. The plan of the individual’s parent(s) is the secondary plan.

If one or more plans cover the same person as a dependent child:

- The primary plan is the plan of the parent whose birthday is earlier in the year if:
  - The parents are married; or
  - The parents are not separated (whether or not they have been married); or

  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage; or
  - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

- If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.
- If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:
  - The plan of the custodial parent;
  - The plan of the spouse of the custodial parent;
  - The plan of the non-custodial parent; and then
  - The plan of the spouse of the non-custodial parent.
- Active or inactive employee: If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or dependent of a retired or laid off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule, as referenced above, can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.
- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See exception in "If You Are Covered by Medicare" on page 79.)
- Longer or shorter length of coverage: The plan that covered the person as an employee, member, subscriber or retiree longer is primary.
- If the above rules do not determine the primary plan, the covered expenses can be shared equally between the plans. This plan will not pay more than it would have paid had it been primary.

If You Are Covered by Medicare

If you or your covered spouse or dependent is also receiving benefits under Medicare, including Medicare prescription drug coverage, federal law may require this plan to be primary over Medicare. When this plan is not primary, the plan will coordinate benefits with Medicare.

Order of Benefit Determination Rules for Medicare

This plan complies with the Medicare secondary payer regulations. Examples of these regulations are as follows:

- This plan generally pays first under the following circumstances:
  - You continue to be actively employed by the employer and you or your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - You continue to be actively employed by the employer, your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through your spouse's former employer. In this case, this plan will be primary for you and your covered spouse, Medicare pays second and the retiree plan would pay last.
  - For a covered person with end-stage renal disease (ESRD), this plan usually has primary responsibility for the claims of a covered person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
  - You are no longer actively employed by an employer; and
  - You or your spouse has Medicare coverage due to age, plus you or your spouse also has COBRA continuation coverage through the plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus you also have COBRA continuation coverage through the plan. Medicare normally pays first; however, an exception is that COBRA may pay first for covered persons with ESRD until the end of the 30-month period; or
  - You or your covered spouse have retiree coverage plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis.)
- Medicare is the secondary payer when no-fault insurance, workers' compensation or liability insurance is available as primary payer.

Expenses for Which a Third Party May Be Responsible (Subrogation)

This plan is designed to cover you and your dependent(s) with health benefits. This plan is not intended to serve as a supplement to, or replacement for, any payments or benefits you or your dependent(s) have or may recover when charges are incurred as the result of an accident,

illness, injury or other medical condition caused by an act or omission of any other party. Benefits under this plan are reduced or excluded subject to the terms and conditions of this subrogation, reimbursement and offset provision anytime there is another party who is liable or responsible (legally or voluntarily) to make payments in relation to the accident, illness or injury.

For purposes of this section, “other party” is defined to include, but is not limited to, the following:

- The party or parties that caused the accident, illness, injury or other medical condition.
- The insurer or other indemnifier of the party or parties who caused the accident, illness, injury or other medical condition.
- The covered person’s own insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment, no-fault insurers or homeowner’s insurance.
- A workers’ compensation or school insurer.
- Any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the accident, illness, injury or other medical condition.

For purposes of this section, recovery is defined to include, but is not limited to, any amount paid or payable by another party through a settlement, judgment, mediation, arbitration or other means in connection with an accident, injury or illness.

If the covered person and/or his or her dependent(s) have the legal right to seek a recovery from such other party, benefits will only be payable if you and your dependents agree to the following:

- That the plan is subrogated to all rights the covered person may have, and you and your dependents acknowledge that the plan will have a first priority lien and right of recovery, on any recovery received from any other party as a result of an accident, illness, injury or other medical condition caused by an act or omission of the other party. Any covered person accepting benefits from the plan assigns from any such recovery an amount equal to the benefits paid by the plan. A covered person further agrees that notice of this assignment presented to the covered person’s attorney and/or insurance company or other party responsible for payment of the damages is binding on the party receiving such notice.
- That the covered person, or their legal representative, shall notify the plan of any claim or potential claim the covered person and/or their dependent(s) have against any other party within 30 days of the act which gives rise to such claim. That, if requested, the covered person or his or her dependent(s) or legal representative shall supply the plan with any information that is reasonably necessary to protect the plan’s subrogation interests.

- If an act or omission of another party causing an accident, illness or injury results in payments being made under the plan, that neither the covered person nor their dependent(s) do anything that would prejudice the plan's rights to recover payments.

- That, if requested, the covered person shall execute documents (including a lien agreement) and deliver instruments and papers and do whatever else is necessary to protect the plan's rights. Such documents may require the covered person to direct their attorney (and other representatives) in writing to retain separately from any recovery that the attorney or representative receive on the covered person's behalf an amount of money sufficient to reimburse the plan as required by such agreement and to pay such money to the plan. Failure or refusal to execute such documents or agreements or to furnish information does not preclude the plan from exercising its right to subrogation or obtaining full reimbursement. In the event the covered person does not sign or refuses to sign such an agreement, the plan has no obligation to make any payment for any treatment required as a result of the act or omission of any other party, such agreement is expressly incorporated in this plan and will be provided to the covered person at any time upon request.

- The plan is also granted a right of reimbursement from the proceeds of any recovery obtained or that may be obtained by the covered person. This right of reimbursement runs concurrent with and is not necessarily exclusive of the plan's subrogation and lien rights described above. A covered person shall promptly convey to the plan any amounts received from any recovery for the reasonable value of the medical benefits advanced by the plan or provided by the plan to the covered person.

- In the event that the covered person fails to cooperate with the plan or fails to comply with the terms of this provision, the plan may offset or otherwise reduce present or future benefits otherwise payable to the covered person or their spouse or dependent under the terms of the plan. Moreover, in the event that a covered person fails to cooperate with the plan, the covered person shall be responsible for any and all costs incurred by the plan in enforcing its rights, including, but not limited to, attorney's fees.

- That the plan has a right to recover, through subrogation, reimbursement, offset or through any other available means, the following:

  - Any amount from the first dollar, that the covered person or any other person or organization on behalf of the covered person is entitled to receive as a result of the accident, illness, injury or other medical condition, to the full extent of benefits paid or provided by the plan; and

  - Any overpayments made directly to providers on behalf of the covered person for the accident, illness, injury or other medical condition.

- That the plan's rights under this section shall be in first priority, to the full extent of any and all benefits paid or payable under the plan, and will not be reduced due to the covered person's own negligence or due to the covered person not being made whole.

- That the covered person shall be solely responsible for all expenses of recovery from any other party, including but not limited to all attorney's fees and costs, which amounts

will not reduce the amount of reimbursement payable to the plan under the operation of any common fund doctrines.

- That the plan will not pay any fees or costs associated with any claim or lawsuit without the plan's express written consent in advance.
- That the covered person or their legal representative or legal guardian, shall be considered a constructive trustee with respect to any recovery received or that may be received from any other party in consideration of an accident, illness, injury or other medical condition for which they have received benefits. Any such funds will be held in trust until the plan's lien is satisfied.
- The plan's rights apply to the covered person, to the spouse and dependent(s) of a covered person, COBRA beneficiaries and any other person who may recover on behalf of a participant, including the covered person's estate.
- That the plan reserves the right to independently pursue and recover paid benefits.
- The plan's subrogation, reimbursement and offset provisions apply to a recovery obtained by the covered person in connection with an accident, injury or illness without regard to the description, name or label applied to the recovery.

COBRA Continuation of Coverage

Important. Read this entire provision to understand a covered person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary provides a general notice of a covered person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. The COBRA administrator, VITA Administration Company, will provide additional information to you or your dependents as required. This summary generally explains:

- COBRA continuation coverage
- When it may become available to you and your family
- What you and your dependents need to do to protect the right to receive it.

Introduction

Federal law gives certain persons, known as qualified beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise terminate. The qualified beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a qualified beneficiary has the same rights and obligations under the plan as an active participant.

A qualified beneficiary may elect to continue coverage under this plan if such person's coverage would terminate because of a life event known as a COBRA qualifying life event, outlined below. When a COBRA qualifying life event causes (or will cause) a loss of coverage, then the plan must offer COBRA continuation coverage.

Generally, you, your covered spouse and your dependent children may be qualified beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election. However, note that COBRA coverage is generally the secondary payer of health care claims for a qualified beneficiary already enrolled in Medicare.

Qualifying Life Events

The length of COBRA continuation coverage that is offered varies based on who the qualified beneficiary is and what qualifying life event is experienced as outlined below.

An employee will become a qualified beneficiary if coverage under the plan is lost because either one of the following qualifying life events happens:

Qualifying Life Event	Length of Continuation
Your employment ends for any reason other than your gross misconduct	Up to 18 months
Your hours of employment are reduced	Up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See “Right to Extend the Length of Continuation Coverage” on page 90 for more information.)

The spouse of an employee will become a qualified beneficiary if coverage is lost under the plan because any of the following qualifying life events happen:

Qualifying Life Event	Length of Continuation
The employee dies	Up to 36 months
The employee’s hours of employment are reduced	Up to 18 months
The employee’s employment ends for any reason other than his or her gross misconduct	Up to 18 months
The employee becomes entitled to Medicare benefits (under Part A, Part B, or both)	Up to 36 months
The employee and spouse become divorced or legally separated	Up to 36 months

The dependent children of an employee become qualified beneficiaries if coverage is lost under the plan because any of the following qualifying life events happen:

Qualifying Life Event	Length of Continuation
The parent/employee dies	Up to 36 months
The parent/employee’s employment ends for any reason other than his or her gross misconduct	Up to 18 months
The parent/employee’s hours of employment are reduced below the minimum needed to remain enrolled by the plan	Up to 18 months
The parent/employee becomes entitled to Medicare benefits (Part A, Part B or both)	Up to 36 months
The parents become divorced or legally separated	Up to 36 months
The child stops being eligible for coverage under the plan as a dependent	Up to 36 months

Notification and Responsibilities

The Notice(s) a Covered Person Must Provide Under This Handbook

To be eligible to receive COBRA continuation coverage, covered employees and their dependents have certain obligations with respect to certain COBRA qualifying life events (including divorce or legal separation of the employee and spouse or a dependent child's loss of eligibility for coverage as a dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either your employer or the COBRA administrator.

A qualified beneficiary's written notice must include all of the following information (a form to notify the COBRA administrator is available upon request):

- The qualified beneficiary's name, their current address and complete phone number
- Name of the employer that the employee was with
- Description of the COBRA qualifying life event (i.e., the life event experienced)
- The date that the qualifying life event occurred or will occur.

Send all COBRA notices or other COBRA information required to be provided by this Handbook in writing to:

VITA Administration Company
900 N. Shoreline Blvd.
Mountain View, CA 94043-1933
650-810-1480

For purposes of the deadlines described in this Handbook, the notice must be postmarked by the deadline. In order to protect your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA administrator.

COBRA Survivor Benefit for Children

If you die while an active employee, your employer will subsidize the cost for the first 12 months of COBRA coverage for your children. For the first 12 months of COBRA coverage, your children's share of the cost is the same as if you were still an active eligible employee. At the end of the 12 months, your children pay the regular COBRA premium for the balance of their COBRA continuation period. Your children must be eligible for COBRA coverage to receive this survivor benefit.

Electing COBRA Coverage

Employer Obligations to Provide Notice of the Qualifying Life Event

Your employer will give notice to the COBRA administrator when coverage terminates due to qualifying life events that are the employee's termination of employment or reduction in hours, death of the employee or the employee becoming entitled to Medicare benefits due to age or disability (Part A, Part B or both). Your employer will notify the COBRA administrator within 30 calendar days when these events occur.

Employee Obligations to Provide Notice of the Qualifying Life Event

The covered person must give notice to the Plan Administrator in the case of other qualifying life events that are divorce or legal separation of the employee and a spouse, a dependent child ceasing to be eligible for coverage under the plan or a second qualifying life event. The covered employee or qualified beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The covered person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the qualifying life event; or
- The date on which there is a loss of coverage (or would lose coverage); or
- The date on which the qualified beneficiary is informed of this notice requirement by receiving this Handbook or the General COBRA Notice.

The Plan Administrator will notify the COBRA administrator within 30 calendar days from the date that notice of the qualifying life event has been provided.

The COBRA administrator will, in turn, provide an election notice to each qualified beneficiary within 14 calendar days of receiving notice of a qualifying life event from the employer, covered employee or the qualified beneficiary.

Making an Election to Continue Group Health Coverage

Each qualified beneficiary has the independent right to elect COBRA continuation coverage. A qualified beneficiary will receive a COBRA election form that must be completed to elect to continue group health coverage under this plan. A qualified beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date plan coverage terminates due to a qualifying life event; or
- The date the Plan Administrator provides the qualified beneficiary with an election notice.

A qualified beneficiary must notify the COBRA administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If the qualified beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the last day of the month following the qualifying life event.

Continued Coverage for Eligible Domestic Partners

Eligible domestic partners do not qualify as qualified beneficiaries under federal COBRA law. Therefore, under federal law, eligible domestic partners do not have the right to elect COBRA independently and separately from the eligible employee.

However, this plan allows eligible domestic partners to elect to continue coverage under a "COBRA-like" extension, separately and independently of eligible employees, subject to the same terms and conditions as outlined for qualified beneficiaries under the COBRA law, when a qualifying life event occurs.

Payment of Claims and Date Coverage Begins

No claims will be paid under this plan for services the qualified beneficiary receives on or after the date coverage is lost due to a COBRA qualifying life event. If, however, the qualified beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated back to the date coverage was lost, provided that the qualified beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will start to be reprocessed by the health insurance carrier once the COBRA administrator receives the completed COBRA election form and required payment.

If a qualified beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the qualifying life event but instead will be effective on the date the waiver is revoked.

Payment for Continuation of Coverage

Qualified beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If your employer offers annual open enrollment opportunities for active employees, each qualified beneficiary will have the same options under COBRA (for example, the right to add coverage for dependents or switch between health plan options). The cost of continuation coverage will be adjusted accordingly.

The initial payment is due no later than 45 calendar days after the qualified beneficiary elects COBRA as evidenced by the postmark date on the envelope or the online election date. This first payment must cover the cost of continuation coverage from the time coverage under the plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for subsequent payments is typically the first day of the month for any particular period of coverage, however the qualified beneficiary will receive specific payment information including due dates and payment grace periods, when the qualified beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any qualified beneficiary receives any benefits under the plan during a month for which the payment was not made on time, then the qualified beneficiary will be required to reimburse the plan for the benefits received.

If the COBRA administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA administrator will notify the qualified beneficiary of the discrepancy and the qualified beneficiary will be required to send a corrected check within the original payment grace period. If a corrected check is not postmarked within the original payment grace period, then the occurrence will be treated as non-payment and the qualified beneficiary(s) will be termed from the plan in accordance with the plan language above.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

Length of Continuation Coverage

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Handbook:

- For employees and dependents — 18 months from the date of loss of coverage following the qualifying life event if due to the employee's termination of employment or reduction of work hours. (If the employee becomes entitled to Medicare and within 18 months experiences a termination of employment or reduction in work hours resulting in a loss of coverage, your covered dependents may elect to continue coverage for the period ending 36 months after the date you became entitled to Medicare.)
- For dependents only — 36 months from the date of loss of coverage following the qualifying life event if coverage is lost due to one of the following events:
  - Employee's death
  - Employee's divorce or legal separation
  - Former employee becomes enrolled in Medicare (if applicable)
  - A dependent child no longer being a dependent as defined in the plan.

Right to Extend the Length of Continuation Coverage

While on COBRA continuation coverage, certain qualified beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA administrator is given as soon as possible but no later than the required timeframes stated below.

Social Security disability determination (for employees and dependents) — A qualified beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA in the event that the Social Security Administration determines the qualified beneficiary to be disabled some time before the 60th day of COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the qualified beneficiary has non-disabled family members who are also qualifying beneficiaries, those non-disabled family members are also entitled to the disability extension.

The qualified beneficiary must give the COBRA administrator a copy of the Social Security Administration letter of disability determination within 60 days of the disability determination and before the end of the initial 18-month COBRA continuation period.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA. (See “COBRA Premium Subsidy for Disabled Employees” on page 91 for more information.)

If the Social Security Administration determines the qualified beneficiary is no longer disabled, the qualified beneficiary must notify the plan of that fact within 30 days after the Social Security Administration’s determination.

Second qualifying life events (dependents only): If your family experiences another qualifying life event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family who are qualified beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA administrator. This additional coverage may be available to the spouse or dependent children who are qualified beneficiaries if the employee or former employee dies, becomes entitled to Medicare (part A, part B or both) or is divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent. This extension is available only if the qualified beneficiaries were covered under the plan prior to the original qualifying life event. A dependent acquired during COBRA continuation (other than newborns and newly-adopted children) is not eligible to continue coverage as the result of a subsequent qualifying life event. These events will only lead to the extension when the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying life event not occurred.

You or your dependents must provide the notice of a second qualifying life event to the COBRA administrator within a 60-day period that begins to run on the latest of:

- The date of the second qualifying life event; or

- The date the qualified beneficiary loses (or would lose) coverage due to the second qualifying life event; or

- The date on which the qualified beneficiary is informed of the requirement to notify the COBRA administrator of the second qualifying life event by receiving this Handbook or the General COBRA Notice.

COBRA Premium Subsidy for Disabled Employees

If COBRA coverage is extended for 29 months because you are disabled, your employer will subsidize the cost of the first 24 months of COBRA coverage (at the same rate as active employees). To be eligible for this subsidy you must be approved for a waiver of premium under the life insurance plan. The subsidy will be equal to the amount that your employer would pay if you were still an active employee.

The subsidy will end on the last day of the month in which one of the following events occurs:

- You cease to be eligible for COBRA coverage due to disability or for waiver of premium under the life insurance plan; or

- You fail to pay timely your share of the COBRA premium; or

- You become eligible for Medicare coverage.

Early Termination of COBRA Coverage

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any employees. (Note that if the employer terminates the group health plan that the qualified beneficiary is under, but still maintains another group health plan for other similarly-situated employees, the qualified beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same.)

- The required contribution for the qualified beneficiary’s coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the qualified beneficiary becomes entitled to and enrolled with Medicare.

- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan.

- The qualified beneficiary is found not to be disabled during the disability extension. The plan will terminate the qualified beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the qualified beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

Alternative to COBRA Coverage

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. The Marketplace offers “one-stop-shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance and copayments) right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being offered COBRA continuation coverage won’t limit your eligibility for coverage or for a tax credit through the Marketplace.

To find out more about enrolling in the Marketplace, such as when the next annual open enrollment period will be and what you need to know about qualifying life events and special enrollment periods, visit www.HealthCare.gov.

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