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Your Health Benefits

The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan as outlined in the Contract between Aetna and the Contractholder.

The following health expense benefits will apply to you only if you have elected such coverage by returning your signed form in accordance with the enrollment procedures of this Plan.

This section explains the main features of the Plan. It includes a corresponding "Summary of Coverage."

Summary of Coverage: Traditional Choice
Booklet Base: Traditional Choice
Issue Date: February 25, 2003
Effective Date: January 1, 2003

Summary of Coverage

Employer: The Department of Defense
Nonappropriated Fund Health Benefits Program

ASC: 721027

SOC: Traditional Choice

Issue Date: February 25, 2003

Effective Date: January 1, 2003

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

Eligibility

Your Coverage

You are in an Eligible Class if you are:

- a Regular Full-Time (RFT) or Regular Part-Time (RPT) civilian employee scheduled to work at least 20 hours per week, who is paid on the U.S. dollar payroll, and who is a U.S. citizen or resident alien living in the United States, the District of Columbia, Puerto Rico or Guam, or

- a Retiree who is eligible to continue participation in the Department of Defense Nonappropriated Fund Health Benefits Program. To be eligible for post-retirement medical coverage, you must be participating in the Plan on the day before retirement, you must retire on an immediate annuity, and you must have 15 years of creditable participation in the DOD Nonappropriated Fund Health Benefits Program. Your employer can provide more detailed information about these requirements.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the date you become part of an Eligible Class.

The following groups are not in an Eligible Class:

- Flexible employees.

Dependents

- **You may cover your:**

- **wife or husband, including a common-law wife or husband in those states that recognize common-law marriages.**

- **unmarried children under 19 years of age.**

- **unmarried children under age 25 who are full-time students in actual attendance at an accredited educational institution, are not working on a regular full-time basis, and depend on you for support.**

- **any child over the maximum age who is determined to be incapable of self-support due to a handicap. Proof of handicap must be submitted to Aetna no later than 31 days after the maximum age is reached. See Child With Disabilities section.**

Your children include:

- Your biological children.
- Your adopted children.
- Your step children who either live with you or are dependent upon you for support.
- Any other child who is not your biological, adopted, or step child, but who lives with you and is dependent upon you for financial support. Evidence proving dependency is required in the form of documentation of legal guardianship or inclusion of the child on your income taxes.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

Your enrollment packet will include a form to complete. Enrollment in the plan may be processed electronically (for the NAF services with health benefits electronic capabilities) or with an enrollment form. This form will allow your Employer to deduct your contributions from your pay to cover your contributions for the plan you elect during enrollment.

IMPORTANT! You must sign, date and return the completed enrollment form to your Human Resources Manager **WITHIN 31 DAYS** of your Eligibility Date for you and your dependents to be covered. Your Human Resource Office representative will sign and date the enrollment form to acknowledge receipt. **If you don't sign and return your form or request to be enrolled within 31 days of your Eligibility Date, you may not elect Health Expense Coverage until the next open enrollment period established by your Employer. If you enroll electronically (for the NAF services with health benefits electronic capabilities), your enrollment must be processed within 31 days of your Eligibility Date.**

If you want DEPENDENT coverage for a newly eligible dependent (for example, you get married or have a baby), complete a new enrollment form (available from your Human Resources Manager) or process electronically (for the NAF services with health benefits electronic capabilities) within 31 days of the Eligibility Date (i.e. date of marriage or baby's date of birth). When you elect DEPENDENT coverage, you must list all their names on the appropriate section of the enrollment form. **If you do not request DEPENDENT coverage within 31 days of the Eligibility Date, you may not elect Health Expense Coverage for such dependent until the next open enrollment period established by your Employer.**

Effective Date of Coverage

Your Coverage

Your coverage will take effect on the later to occur of:

- your Eligibility Date; or
- the date you return your signed group coverage enrollment form to your Human Resource Manager or the date your enrollment is processed electronically.

If you do not sign and return your form or request to be enrolled within 31 days of your Eligibility Date, you will not be able to elect coverage until the next open enrollment period established by your Employer.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions. If you do not do so within 31 days of any dependent's Eligibility Date, you will not be able to elect coverage for such dependent until the next open enrollment period established by your Employer.

- If you have EMPLOYEE COVERAGE ONLY and you request DEPENDENT coverage for a *newly eligible* dependent **within 31 days** of their Eligibility Date, the effective date of DEPENDENT coverage is the date of the election.

- If you have EMPLOYEE COVERAGE and want to change to DEPENDENT coverage but did not request such coverage **within 31 days** of this Eligibility Date, you will not be able to elect coverage for such dependent until the next open enrollment period established by your Employer.

Special Enrollment Procedures Under HIPAA

You will be able to elect coverage at any time after 31 days without waiting for the next open enrollment period if:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:

  the person was covered under other "creditable coverage" as defined below; and

  you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and

- the person loses such coverage because:

  of termination of employment in a class eligible for such coverage;

  of reduction in hours of employment;

  your spouse dies;

  you and your spouse divorce or are legally separated;

  such coverage was COBRA like continuation and such continuation was exhausted; or

  the other plan terminates due to the employer's failure to pay the premium or for any

other reason; and

- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

Coverage will be effect on the date of the change in status.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

Also, you will be able to elect coverage without waiting for the next open enrollment period if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A spouse or child who meets the definition of a dependent, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order.
- Yourself, and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election.
- Yourself, and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.
- Yourself and your spouse, and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits the election of coverage until the next open enrollment period will not apply to a child who meets the definition of a dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order (QMCSO). Upon receipt of a QMCSO, coverage of the child is not optional; your employer is required to enroll the child in the plan whether you request the enrollment or not. This coverage is mandated by the terms of the QMCSO. If your enrollment in the plan is required in order to provide health coverage for the child, your employer will also enroll you. Coverage will be effective on the date of the court order. If you are currently not enrolled and are eligible for coverage in the health plan, your employer will enroll you and your dependent(s) for family coverage as of the date on the court order.

If you are the non-custodial parent, proof of a health benefit claim for the dependent child may be given by the custodial parent. Benefits for a claim will be paid to the custodial parent.

Health Expense Coverage

Employees and Dependents

This Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in this Booklet for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Prescription Drug Expense Coverage

Prescription Drug Coverage

When the prescription is purchased through:	**And the prescription is for a "generic" drug, the expense is covered at:**	**And the prescription is for a "brand-name" drug listed on the Aetna's current formulary, the expense is covered at:**	**And the prescription is for a "brand-name" drug not listed on the Aetna's current formulary, the expense is covered at:**
Mail Order Pharmacy - Express Pharmacy Services *	100% after a $10 copay per prescription or refill for up to a 90-day supply	100% after a $20 copay per prescription or refill for up to a 90-day supply	100% after a $30 copay per prescription or refill for up to a 90-day supply
A Participating Pharmacy	100% after a $10 copay per prescription or refill up to a 30-day supply	100% after a $20 copay per prescription or refill up to a 30-day supply	100% after a $30 copay per prescription or refill up to a 30-day supply
A Non-Participating Pharmacy in the US	No Coverage	No Coverage	No Coverage
Overseas Pharmacies	100% after deductible	80% after deductible	80% after deductible

* The Mail Order Pharmacy feature of the Prescription Drug Benefit is designed to be used by individuals using maintenance type medication for the treatment of chronic or long-term conditions such as, but not limited to, diabetes, arthritis, heart conditions and high blood pressure, for periods of 30 days or longer. This program covers any prescription drug covered by the Plan.

Copayments as listed above are to be paid at the Participating Pharmacy at the time of purchase. No other prescription drug benefits are payable. Do not submit prescription drug claims for prescription drugs obtained in the U.S.

Refills for prescription drugs will be filled in accordance with the terms of the Plan, provided that:

- *for a 10 to 30 day supply at least 50% of the prior prescription or refill has been used; or*
- *for a supply greater than 30 days at least 75% of the prior prescription or refill has been used; or*
- *for a supply furnished by a* ***mail order pharmacy*** *at least 60% of the prior prescription or refill has been used.*

The date of the most recent prescription or refill will be used to determine the percentage used.

Comprehensive Medical Expense Coverage

Certification Requirement

You must obtain certification for certain types of Non-Preferred Care to avoid a reduction in benefits paid for that care. Read the Special Comprehensive Medical Expense Benefits section of the Booklet for details of the types of care affected, how to get certification and the effect on your benefits for failure to obtain certification.

Certification for Hospital Admissions is required.

If you do not obtain certification, the following Penalty in the form of an Excluded Amount of coverage will apply:

Excluded Amount (Penalty)	$ 500

NOTE: Obtaining certification for Hospital Admissions is not required for participants receiving treatment outside the United States.

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet.

Deductible Amounts

Individual Calendar Year Deductible	$ 200
Family Calendar Year Deductible	$ 600

Payment Percentage	
Preventive Care	
Routine Physical Exam and Immunizations Expenses	100%, no deductible
Routine Gynecological Exam Expenses	100%, no deductible
Routine Mammography Expenses	100%, no deductible
Routine Prostate Cancer Screening Expenses	100%, no deductible
Routine Eye Exam Expenses	80%, no deductible
Prescription Eyewear Reimbursement Expenses $75 Calendar Year Benefit Maximum	100%, no deductible
Routine Hearing Exam Expenses	100%, no deductible
Hearing Aid Expenses $500 Lifetime Maximum	100%, no deductible
Physician Services	
Office Visit Expenses for Treatment of Illness or Injury	80% after deductible
In Office Diagnostic Lab and X-ray Expenses	80% after deductible
Maternity Care Office Visit Expenses	80% after deductible
In-office Surgical Expenses	100% of first $1,000 no deductible; then 80% after deductible
Physician Hospital Visit Expenses	80% after deductible
Anesthesia	80% after deductible
Allergy Testing, Serum and Injections	80% after deductible
Second Surgical Opinion Expenses	100%, no deductible
Hospital Services	
Inpatient and Outpatient hospital room and board and ancillary services	80% after deductible
Inpatient Surgical Expenses	80% after deductible
Preoperative Testing Expenses	80%, no deductible

Outpatient Surgical Expenses	80% after deductible

Emergency Care

Hospital Emergency Room Expenses	80% after deductible
Hospital Emergency Room for Non-emergency Care	50% after deductible
Ambulance	80% after deductible

Other Health Care

Convalescent Facility Calendar Year Maximum - 90 Days	80% after deductible
Home Health Care Calendar Year Maximum - 90 Visits	80% after deductible
Private Duty Nursing Calendar Year Maximum - 70 eight hour shifts	80% after deductible
Hospice Care Expenses	100%, no deductible
Independent Lab and X-ray Facilities	80% after deductible
Short Term Rehabilitation 60 Visit Maximum Per Course of Treatment	80% after deductible
Durable Medical Equipment	80% after deductible
Spinal Disorder Treatment Calendar Year Maximum - 20 Visits	80% after deductible
National Medical Excellence Travel and Lodging Expenses Limited to $50 a night per person with a $100 per night maximum up to $10,000 maximum per procedure or treatment.	100% no deductible
Other Medical Expenses for which a Payment Percentage is not otherwise shown	80% after deductible

Private Room Limit	The institution's semiprivate rate (private rate if a private room is medically necessary).

***Lifetime Maximum Benefit**:* There is no Lifetime Maximum Benefit (overall limit) that applies to the Comprehensive Medical benefits described in this Booklet. The only maximum benefit limits are those specifically mentioned in this Booklet.

Payment Percentage and Special Maximums for Alcoholism, Drug Abuse and Mental Disorders

Alcoholism and Drug Abuse

Inpatient	
Calendar Year Maximum – 45 Days	80% after deductible
Outpatient	
Calendar Year Maximum – 45 Visits	80% after deductible

Mental Disorders

Inpatient	80% after deductible; up to 60 days per calendar year; 50% thereafter
Outpatient	
Calendar Year Maximum – 45 Visits	80% after deductible

Out-of-Pocket Limits

These limits apply to Covered Medical Expenses which are payable at a rate greater than 50%.

Out-of-Pocket Limit Which Applies to Expense for an Individual

When an individual's Covered Medical Expenses for which no benefits are paid because of the deductible and the Payment Percentage reach $2,000 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Out-of-Pocket Limit Which Applies to Expense for a Family

When a family's Covered Medical Expenses for which no benefits are paid because of the deductible and the Payment Percentage reach $6,000 in a calendar year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Maternity Coverage

Benefits are payable for maternity-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement, such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.

The expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, no benefits will be paid.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

Additional Information Provided by The Department of Defense Nonappropriated Fund Health Benefits Program

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

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

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

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

Health Expense Coverage

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

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

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

Comprehensive Medical Expense Coverage

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

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Medical Expenses described below.

Covered Medical Expenses

They are the expenses for certain **hospital** and other medical services and supplies. They must be for the treatment of an injury or disease. Here is a list of Covered Medical Expenses.

Hospital Expenses

Inpatient Hospital Expenses

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

Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.

Outpatient Hospital Expenses

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

Hospital stays in the 50 states must be certified to obtain full benefits. (See the Summary of Coverage for details.)

Routine Physical Exam Expenses and Well Child Care

The charges made by a **physician** for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. If charges made by a **physician** in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included as a part of the exam are:

- X-rays, laboratory and other tests given in connection with the exam; and
- Charges for one routine gynecological exam, including pap smear during any calendar year; and
- Charges for one screening by mammography given to a female age 35 or over for the presence of occult breast cancer; and
- Charges in connection with one screening for cancer of the prostate, including a prostate specific antigen (PSA) test and a digital rectal exam, given to a male age 40 and over during any one calendar year; and
- Materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For your dependent child:

- The physical exam must include at least:

  a review and written record of the patient's complete medical history;

  a check of all body systems; and

  a review and discussion of the exam results with the patient or with the parent or guardian.
- For all exams given to your dependent child under age 2, Covered Medical Expenses will not include charges for:

  more than 6 exams performed during the first year of the child's life;

  more than 2 exams performed during the second year of life; and

  more than one exam performed during each year of life thereafter.

For all exams given to you and your spouse, Covered Medical Expenses will not include charges for more than one exam per calendar year.

Limitations To Routine Physical Exam and Well Child Care Expenses

Not covered are charges for:

- Services which are covered to any extent under any other group plan of your Employer.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease
- Exams given while the person is confined in a **hospital** or other facility for medical care.
- Services which are not given by a **physician** or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.

- Vision, hearing or dental exams.
- A **physician's** office visit in connection with immunizations or testing for tuberculosis.

NOTE: These limitations apply to Routine Physical Exam and Well Child Care Expenses only. They may be included as Covered Expenses in other areas of your coverage.

High-Risk Factors

In addition to normal screenings and immunizations performed in connection with a routine physical exam, certain screenings and immunizations will be covered for persons identified as being at a higher risk for certain diseases or conditions. These procedures include the following:

Serum Cholesterol (HDL)

Testing for serum cholesterol will be provided once between two and six years of age, and once every five years thereafter for children with a family history (either a biological parent or grandparent) of premature cardiovascular disease*, or where a biological parent has had hypercholosterolemia**.

* Premature cardiovascular disease is defined as the onset of such a disease at an age equal to or less than fifty-five years old.

** Hypercholosterolemia is defined as a total cholesterol level greater than 240 mg/dl.

Tuberculin (PPD) Testing

For children, high-risk factors for tuberculosis will include but are not limited to:

- The child has had contact with adults with infectious tuberculosis.
- The child was born in a foreign country or region, or has parents who were born in a foreign country or region, where tuberculosis is common.
- The child exhibits clinical evidence of tuberculosis.
- The child is HIV seropostitve.
- The child has other medical conditions, including but not limited to, Hodgkin's disease, lymphoma, diabetes mellitus, chronic renal failure and malnutrition.
- The child is an incarcerated adolescent.
- The child is frequently exposed to: HIV infected individuals, homeless persons, users of intravenous drugs and other street drugs, poor and medically-indigent city dwellers, residents of nursing homes, or migrant farm workers.

Testing will be provided in accordance with your Routine Physical Exam and Well Child Care benefit when determined necessary.

For Adults, high-risk factors for tuberculosis will include but are not limited to:

- Persons with signs, symptoms, or laboratory abnormalities suggestive of clinically active tuberculosis.
- Recent contacts with persons known to have or suspected of having clinically active tuberculosis.
- Persons with HIV infection.
- Persons with abnormal chest x-rays compatible with past tuberculosis.
- Persons with other medical conditions that increase the risk for tuberculosis.
- Persons who have been determined to be part of a group at high risk of recent M. tuberculosis, such as immigrants from foreign countries where tuberculosis is common, medically underserved populations.

Testing will be provided in accordance with your Routine Physical Exam benefit when determined necessary.

Lead Screening

For children age 6 months through 6 years one screening will be performed if it is determined that there is a high risk of lead poisoning. High-risk factors include but are not limited to:

- Living in a dwelling built before 1960 with peeling or chipped paint, or where renovations have recently been made.
- Living near a factory where lead is used or released into the environment.
- A sibling, playmate, or other household member is currently being treated for lead poisoning.
- A household member has a job or hobby involving exposure to lead.

Hepatitis B Vaccination

Three doses will be provided for persons age 20 and over only if such person is determined to be in a high risk group. High-risk factors include but are not limited to:

- Persons with an occupational risk of contracting Hepatitis B.
- Hemodialysis patients.
- Individuals with bleeding disorders who receive blood products.
- Persons who have household or sexual contact with persons known to be Hepatitis B carriers.
- Persons who are intravenous illicit drug users.
- Persons who are sexually active homosexual or bisexual males.
- Persons who are heterosexual and who have or have had more than one sex partner in the past six months, or who have recently contracted a sexually transmitted disease.
- Persons who are international travelers to geographic areas where Hepatitis B is common.
- Persons who are inmates of long term correctional facilities.

Menginococcal Vaccination

One dose will be provided for children age 2 and over (or once for adults if it has not been previously administered) with one or more of the following high-risk factors:

- Persons with asplenia (sickle-cell disease).
- Persons with anatomic asplenia (surgical or congenital).

Pneumovax

One dose will be provided for children age 2 or older (or for adults if it has not been previously administered) with one or more the following high-risk factors:

- Persons infected with HIV or AIDS.
- Persons with asplenia (sickle-cell disease).
- Persons with anatomic asplenia (surgical or congenital).

Routine Eye Exam Expenses

Covered Medical Expenses include charges for a complete eye exam, including refraction, which is furnished by a legally qualified ophthalmologist or optometrist to a person.

Covered Medical Expenses will not include charges for more than one eye exam per calendar year.

Limitations To Routine Eye Exam Expenses

Not included as Routine Eye Exam Expenses are charges for:

- any eye exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any services or supplies which are included as covered expenses under any other benefit section included in this Plan or under any other plan of group benefits provided through your Employer;
- any services or supplies for which benefits are provided under any workers' compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges;
- any service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a **hospital** or other facility for medical care;
- any eye exam required by an employer as a condition of employment, or an employer is required to provide under a labor agreement or is required by any law of a government.

NOTE: These limitations apply to Routine Eye Exam Expenses only. They may be included as Covered Expenses in other areas of your coverage.

Prescription Eyewear Reimbursement

Covered Medical Expenses will include those for medically necessary prescription eyewear (lenses, frames, and contact lenses). Covered expenses will be payable at 100%, not subject to the deductible, for any combination of medically necessary prescription eyewear up to the Prescription Eyewear Reimbursement Maximum of $75 per calendar year, per person.

Routine Hearing Exam Expenses

Covered Medical Expenses include charges for an audiometric exam. The services must be performed by:

a **physician** certified as an otolaryngologist or otologist; or

an audiologist who either:

is legally qualified in audiology; or

holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and

who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Covered Medical Expenses will be payable at 100%, not subject to a deductible, and will not include charges for more than one hearing exam per calendar year.

Limitations to Routine Hearing Exam Expenses
Not included as Routine Hearing Exam Expenses are charges for:

- any ear or hearing exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- any hearing care service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a **hospital** or other facility for medical care; or
- any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government.

NOTE: These limitations apply to Routine Hearing Exam Expenses only. They may be included as Covered Expenses in other areas of your coverage.

Hearing Aid Expenses

Covered Medical Expenses include charges for a hearing aid evaluation and audiometric exam, and for a hearing aid if installed in accordance with a prescription written during such exam, which is performed by:

a **physician** certified as an otolaryngologist or otologist; or

an audiologist who either:

is legally qualified in audiology; or

holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and

who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Covered Medical Expenses will be payable at 100% and not subject to a deductible.

Benefits After Termination of Coverage
If an individual's coverage terminates expenses incurred for a hearing aid within 30 days of termination of the individual's coverage under the Plan will be considered to be a Covered Medical Expense if:

the prescription for the hearing aid was written; and

the hearing aid was ordered;

during the 30 days before coverage ended.

Limitations to Hearing Aid Expenses
No benefits will be payable as to the following:

Charges for a hearing aid which is included as a covered expense under any other benefit section of this Plan or under any other plan carried or sponsored by your employer.

Charges for a hearing aid for which benefits are provided under any workers' compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges.

Charges for a hearing aid which does not meet professionally accepted standards and charges for any hearing aid that is experimental.

Charges for batteries, for replacement of lost, stolen, or broken hearing aids, for replacement parts or repairs for hearing aids.

Charges for a hearing aid which is received while the individual is not covered or charges for hearing aids which are furnished or ordered as a result of a hearing exam which occurred prior to the date the individual became covered.

Charges in excess of the $500 Hearing Aid Expense Lifetime Maximum.

NOTE: These limitations apply to Routine Hearing Aid Expenses only. They may be included as Covered Expenses in other areas of your coverage.

Second Surgical Opinion Expenses

Charges of a **physician** for a second surgical opinion on the need or advisability of performing a surgical or oral surgical procedure:

- for which the charges are a Covered Medical Expense; and
- which is recommended by the first **physician** who proposed to perform the surgery; and
- which is not for an **emergency condition**.

A benefit is also paid for charges made for a third surgical opinion. This will be performed when the second one does not confirm the recommendation of the first **physician** who proposed to perform the surgery.

A surgical opinion is:

- an exam of the person; and
- x-ray and lab work; and
- a written report by the **physician** who renders the opinion.

The surgical opinion must both:

- be performed by a **physician** who is certified by the American Board of Surgery or other specialty board; and
- take place before the date the proposed surgery is scheduled to be performed.

Benefits are not paid for a surgical opinion if the **physician** who renders the surgical opinion is associated or in practice with the first **physician** who recommended and proposed to perform the surgery.

Preoperative Testing Expenses

Charges made by a **hospital**, **surgery center**, licensed diagnostic lab facility, or **physician**, in its own behalf, to test a person while an outpatient before scheduled surgery if:

- the tests are related to the scheduled surgery;
- the tests are done within the 7 days prior to the scheduled surgery;
- the person undergoes the scheduled surgery in a **hospital** or **surgery center**; this does not apply if the tests show that surgery should not be done because of his physical condition;
- the charge for the surgery is a Covered Medical Expense under this Plan;
- the tests are done while the person is not confined as an inpatient in a **hospital**;
- the charges for the tests would have been covered if the person was confined as an inpatient in a **hospital**;
- the test results appear in the person's medical record kept by the **hospital** or **surgery center** where the surgery is to be done; and
- the tests are not repeated in or by the **hospital** or **surgery center** where the surgery is done.

If the person cancels the scheduled surgery, benefits are paid at the payment percentage that would have applied in the absence of this benefit.

Surgical Expenses

These are the charges made by a physician for surgical services. Surgical Services are the services of the operating physician in performing a surgical procedure. A "surgical procedure" is:

- The incision or excision of any part of the body.
- The electrocauterization of any part of the body.
- The manipulative reduction of a fracture or dislocation.
- The suturing of a wound.
- Voluntary sterilization.
- The removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder or ureter.

Included as part of a "surgical procedure" are the following services of the operating physician:

- The usual and related preoperative care.
- The administering of anesthetic.
- The usual and related postoperative care.

The Medical Plan normally pays a lesser percentage of the fees charged for the secondary procedures when more than one surgical procedure is performed at one time or during a single operating session. Surgical preparation and other fees are included in the fee for the primary surgery.

Limitations to Surgical Expenses

Not covered as Surgical Expenses are charges for:

- Diagnostic laboratory and x-ray services.
- Drugs or medicines.
- Services of a resident physician or intern of a hospital.
- Reversal of sterilization.

NOTE: These limitations apply to Surgical Expenses only. They may be included as Covered Expenses in other areas of your coverage.

Outpatient Surgical Expenses

Charges made in its own behalf by:

- A **surgery center**; or
- The outpatient department of a **hospital**;

for Outpatient Services and Supplies furnished in connection with a surgical procedure performed in the center or in a **hospital**. The procedure must meet these tests:

- It is not expected to:

  result in extensive blood loss;
  require major or prolonged invasion of a body cavity; or
  involve any major blood vessels.
- It can safely and adequately be performed only in a **surgery center** or in a **hospital**.
- It is not normally performed in the office of a **physician** or a **dentist**.

Outpatient Services and Supplies

These are services and supplies furnished by the center or by a **hospital** on the day of the procedure.

Limitations to Outpatient Surgical Expenses

No benefit is paid for charges incurred while the person is confined as a full-time inpatient in a **hospital**.

NOTE: These limitations apply to Outpatient Surgical Expenses only. They may be included as Covered Expenses in other areas of your coverage.

Acupuncture Expenses

Covered Medical Expenses include those charges incurred for acupuncture therapy treatments when the treatment is performed by (not under the direction of) a physician for the treatment of any one of the following illnesses:

- Sciatica;
- Neuritis;
- Postherapeutic Neuralgia;
- Tic Douloureux;
- Chronic Headaches (e.g. migraine);
- Osteoarthritis;
- Rheumatoid Arthritis; or
- Myofascial Complaints (e.g. neck and lower back pains).

Acupuncture when performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan is included as Covered Medical Expenses.

Acupuncture is considered a non-surgical procedure as it does not involve incision in accordance with a surgical procedure.

Convalescent Facility Expenses

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

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.

- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physicians** services.
- Medical supplies.

Benefits will be paid for no longer than the Convalescent Days during any one calendar year.

Limitations To Convalescent Facility Expenses
This section does not cover charges made for treatment of:

- Drug addiction.
- Non-psychotic chronic organic brain syndrome.*
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

*Non-psychotic chronic organic brain syndrome (disease) means a basic mental condition of variable duration characteristically resulting from diffuse or generalized impairment of brain tissue function from whatever cause. The duration of the condition can vary.

NOTE: These limitations apply to Convalescent Facility Expenses only. They may be included as Covered Expenses in other areas of your coverage.

Home Health Care Expenses

Home health care expenses are covered if:

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

Home health care expenses are charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or **convalescent facility**:

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  lab services provided by or for a **home health care agency**.

There is a maximum to the number of visits covered in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Health Care Expenses
This section does not cover charges made for:

- Services or supplies that are not a part of the **home health care plan**.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.

- Transportation.

NOTE: These limitations apply to Home Health Care Expenses only. They may be included as Covered Expenses in other areas of your coverage.

Hospice Care Expenses

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses

The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**;
- **convalescent facility**;

which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:

  pain control; and

  other acute and chronic symptom management.
- Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit
- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses

Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:
  assessment of the person's social, emotional, and medical needs; and the home and family situation;
  identification of the community resources which are available to the person; and assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a **physician**.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.

Charges made by the providers below, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.

- A **Home Health Care Agency** for:

  physical and occupational therapy;

part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;

medical supplies;

drugs and medicines prescribed by a **physician**; and

psychological and dietary counseling.

Limitations To Hospice Care Expenses
Not included are charges made:

- For bereavement counseling, except for counseling of the immediate family.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

NOTE: These limitations apply to Hospice Care Expenses only. They may be included as Covered Expenses in other areas of your coverage.

Infertility Services Expenses

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for infertility if all of the following tests are met:

- There exists a condition that is a demonstrated cause of infertility and has been recognized by a gynecologist or infertility specialist.
- The procedures are performed while not confined in a **hospital** or any other facility as an inpatient.
- For a female under age 35, she has not been able to conceive after one year or more without contraception or 12 cycles of artificial insemination; and for a female age 35 and older, she has not been able to conceive after six months without contraception or 6 cycles of artificial insemination.
- FSH levels are less than or equal to 19 miU on day 3 of the menstrual cycle.
- The infertility is not caused by voluntary sterilization or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

The following infertility services expenses will be Covered Medical Expenses:

- Monitoring of ovulation induction with ovulatory stimulant drugs, subject to a maximum of 6 courses of treatment in a covered person’s lifetime.
- Artificial insemination, subject to a maximum of 6 courses of treatment in a covered person’s lifetime.

These expenses will be covered on the same basis as for disease.

A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.

In figuring the above Lifetime Maximums, Aetna will take into consideration all of the

following, whether past or present:

- Services received while covered, under a plan of benefits on an individual or group basis, whether insured or self-insured, offered by Aetna or one of its affiliated companies; and
- Services received while covered under a plan of benefits on an individual or group basis, whether insured or self-insured, offered by any other carrier; and
- Services received while no plan coverage was provided.

Not covered are charges for:

- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Cryopreservation or storage of cryopreserved embryos.
- Gestational carrier programs.
- **Prescription drugs**, including injectable infertility medications (coverage for injectable infertility medications is described in the section on Prescription Drug Benefits).
- Home ovulation prediction kits.
- In vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection.
- Frozen embryo transfers, including thawing.
- Reversal of sterilization surgery.

Short-Term Rehabilitation Expenses

The charges made by:

- a **hospital** or licensed health care facility; or
- a **physician**; or
- a licensed or certified physical, occupational, or speech therapist;

for the following services for treatment of acute conditions are Covered Medical Expenses.

Short-Term Rehabilitation is therapy which is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to:

- an injury;
- a disease; or
- congenital defect.

Short-Term Rehabilitation services consist of:

- physical therapy;
- occupational therapy; or
- speech therapy;

furnished to a person who is not confined as an inpatient in a **hospital** or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

The charges for Short-Term Rehabilitation services are Covered Medical Expenses for no longer than the Short-Term Rehabilitation Maximum Days for each person per course of treatment.

Limitations to Short-Term Rehabilitation Expenses

Not covered as Short-Term Rehabilitation Expenses are charges for:

- Services which are covered to any extent under any other part of this Plan.
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an Employer.
- Services received while the person is confined in a **hospital** or other facility for medical care.
- Services not performed by a **physician** or under his or her direct supervision.
- Services rendered by a physical, occupational, or speech therapist who resides in the person's home or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from:

  disease;

  injury; or

  congenital defect.
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.

- Treatment for which a benefit is or would be provided under the Spinal Disorder Expenses section, whether or not benefits for the maximum number of visits under that section have been paid.

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:

- details the treatment to be rendered and the frequency and duration of the treatment.
- provides for ongoing reviews and is renewed only if therapy is still necessary.

Other Medical Expenses

These Other Medical Expenses are covered at the Payment Percentage indicated on the applicable Summary of Coverage after any applicable deductible is met. They include:

- Charges made by a **physician**.
- Charges made by a **R.N.** or **L.P.N.** or a nursing agency for skilled nursing care.

  As used here, "skilled nursing care" means these services:

  Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.

  Private duty nursing by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

  Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

  Not included as "skilled nursing care" is:

  that part or all of any nursing care that does not require the education, training, and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs, and companionship activities; or

any private duty nursing care given while the person is an inpatient in a **hospital** or other health care facility; or

care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or

care provided solely for skilled observation except as follows:

for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:

change in patient medication;

need for treatment of an **emergency condition** by a **physician** or the onset of symptoms indicating the likely need for such treatment;

surgery; or

release from inpatient confinement; or

any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

- Charges for the following:

Drugs and medicines which by law need a **physician's** prescription and are dispensed by a **non-preferred pharmacy**.

Diagnostic lab work and X-rays.

X-ray, radium, and radioactive isotope therapy.

Anesthetics and oxygen.

Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

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

Repair of purchased equipment.

Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.

Artificial limbs and eyes. Not included are such things as:

eyeglasses;

vision aids;

hearing aids;

communication aids; and

orthopedic shoes, foot orthotics, or other devices to support the feet.

National Medical Excellence Program ® (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

Travel Expenses

These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses

These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum

For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:

  one year after the day the procedure is performed; and

  the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Limitations
Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

Limitations

Mouth, Jaws, and Teeth

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

- services rendered; and
- supplies needed;

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

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

For these expenses, **physician** includes a **dentist**.

Surgery needed to:

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

  teeth partly or completely impacted in the bone of the jaw;

  teeth that will not erupt through the gum;

  other teeth that cannot be removed without cutting into bone;

  the roots of a tooth without removing the entire tooth;

  cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

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

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

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the calendar year of the accident or the next one.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only charges for:

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

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for routine tooth removal (not needing cutting of bone).

Limitations to Mouth, Jaws and Teeth Expenses
Not included are charges:

- to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, in-mouth scaling, planing or scraping;
- for myofunctional therapy; this is:

  muscle training therapy; or training to correct or control harmful habits.

Emergency Room Treatment

Emergency Care
If treatment:

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

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Payment Percentage after any applicable deductible.

Non-Emergency Care
If treatment:

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

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Reduced Payment Percentage, after any applicable copay or deductible.

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

Spinal Disorder Treatment

There is a calendar year benefit maximum which applies to Covered Medical Expenses incurred for:

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

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Disorder Treatment Calendar Year Maximum will be payable in any one calendar year for all expenses in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating **physician**.

Certification For Hospital Admissions

NOTE: Make sure you, your dependents and your physician know about the certification requirement under your plan. This is especially important in case of an emergency if you are unable to obtain certification for yourself.

How To Obtain Certification
Certification of days of confinement can be obtained as follows:

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

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

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

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

If:

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

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

- As to Hospital Expenses incurred during the confinement:

  If certification has been requested and denied:

  No benefits will be paid for any Hospital Expenses including charges for board and room.

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

  No benefits will be paid for any Hospital Expenses including charges for board and room.

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

  Hospital Expenses incurred for board and room, up to the Excluded Amount (Penalty), will not be deemed to be Covered Medical Expenses.

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

- As to other Covered Medical Expenses:

  Benefits will be paid at the Payment Percentage.

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

Treatment of Alcoholism, Drug Abuse, or Mental Disorders

Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment

If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Hospital

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Effective treatment of alcoholism or drug abuse**.
- Treatment of **mental disorders**.

Treatment Facility
Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Other **necessary** services and supplies.

Calendar Year Maximum Benefit
A Special Inpatient Calendar Year Maximum Days applies to the **hospital** and **treatment facility** expenses described above.

Outpatient Treatment
If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital**, **treatment facility** or **physician**, benefits will not be payable for more than the Maximum Visits in any one calendar year.

Prescription Drug Expense Coverage

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all prescription drugs. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in this Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

An Explanation of Certain Terms

Prescription Drugs. Any of the following:
- A drug, biological, or compounded **prescription** which, by Federal Law: may be dispensed only by **prescription** and which is required to be labeled "Caution : Federal Law prohibits dispensing without **prescription**."
- Injectable insulin, glucose test strips and lancets.
- Injectable fertility drugs.
- Disposable needles and syringes which are purchased to administer a covered injectable prescription drug or agent.

Participating Agreement. An agreement between Aetna and a Pharmacy with terms regarding payment for Prescription Drugs dispensed under the agreement.

Pharmacy. An establishment where Prescription Drugs are legally dispensed.

Mail Order Pharmacy. An establishment where Prescription Drugs are legally dispensed by mail.

Participating Pharmacy (Preferred Pharmacy) A Pharmacy, including a Mail Order

Pharmacy, which is party to an Agreement with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the Participating Agreement remains in effect; and
- when such a Pharmacy dispenses a Prescription Drug under the terms of its Participating Agreement with Aetna.

Non-Participating Pharmacy (Non-Preferred Pharmacy). A Pharmacy not party to a Participating Agreement with Aetna, or a Pharmacy who is party to such a Participating Agreement but who does not dispense Prescription Drugs in accordance with its terms.

Prescriber. A physician or dentist who is licensed in the United States and has the legal authority to write an order for a Prescription Drug.

Prescription. An order of a Prescriber for a Prescription Drug. If it is an oral order, it must be promptly put in writing by the Pharmacy.

Generic Prescription Drug or Medicines. A Prescription Drug which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Formulary. A listing of prescription drugs which have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both brand name drugs and generic drugs and is subject to periodic review and modification by Aetna. For more information about the Formulary, visit Aetna's website at www.aetna.com. You may also call the Aetna Customer Service number on your ID card for information.

Service Area. This is the geographic area, as determined by Aetna, in which Preferred Pharmacies for this Plan are located.

Emergency Situation. This means the sudden and at that time, unexpected onset of a change in a person's physical or mental condition which, if the treatment was not performed right away could, as determined by Aetna, reasonably be expected to result in:

- loss of life or limb; or
- significant impairment to bodily function; or
- permanent dysfunction of a body part.

Prescription Drug Expense Benefit

If a Prescription Drug is dispensed by a Preferred Pharmacy to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount section, but only if the Preferred Pharmacy's charge for the drug is more than the Copay per prescription or refill.

In an emergency situation only, a benefit will be paid determined from the Benefit Amount section, for a Prescription Drug dispensed by a Non-Preferred Pharmacy.

Benefit Amount

The Benefit Amount for each covered Prescription Drug or refill will be an amount equal to the Payment Percentage (100%) of the total charges in excess of the Copay per prescription or refill as shown in the Summary of Coverage. The total charge is determined by:

- the Preferred Pharmacy, including a Mail Order Pharmacy; and
- Aetna.

Any amount so determined will be paid to the Preferred Pharmacy on your behalf.

No benefit will be paid for a Prescription Drug dispensed by a Non-Preferred Pharmacy under this benefit section, except in an emergency situation. In an emergency situation, the benefit amount for each covered Prescription Drug or refill is equal to the Payment Percentage (100%) of the Preferred Pharmacy's charge for the drug, in excess of the Copay per prescription or drug.

Limitations

No benefits are paid:

- For a device of any type unless specifically included above as Prescription Drugs.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 30 day supply of any drug dispensed by a Mail Order Pharmacy.
- For the administration or injection of any drug.
- For contraceptive drugs, except oral and injectable contraceptives.
- For more than 48 dispensing kits per year for injectable drugs which are used for treatment of migraine headaches.
- For appetite suppressants and weight control drugs.
- For any smoking cessation aids or drugs. However, Nicorette may be covered as an "Other Medical Expense" under your Comprehensive Medical Expense Coverage if Aetna determines such aid is medically necessary to treat certain conditions accentuated by smoking.
- For cosmetic drugs.(e.g., Rogaine).
- For immunization agents (e.g., routine or travel related).
- For any "over the counter" drugs (non-prescription) unless specifically included in the definition of a prescription drug.
- For any prescription drugs obtainable without a prescription on an "over-the counter" basis.
- For more than a 30 day supply per prescription or refill. However, this limitation does not apply to a supply of up to 90 days per Prescription or refill for drugs which are provided by a Mail Order Pharmacy.
- For any refill of a drug if it is more than the number of refills specified by the Prescriber. Aetna, before recognizing charges, may require a new Prescription, or evidence as to need, if the Prescriber has not specified the number of refills, or if the frequency or number of Prescriptions or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest Prescription for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any healthcare facility; or for any drug provided on an outpatient basis in any such institution to the extent benefits are paid for it under any other part of this Plan, or under any other medical or prescription drug expense benefit plan carried or sponsored by your Employer.

General Exclusions

General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

  there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

  if required by the FDA, approval has not been granted for marketing; or

  a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

  the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

  However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

  the disease can be expected to cause death within one year, in the absence of effective treatment; and

  the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

  Also, this exclusion will not apply with respect to drugs that:

  have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

  are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

  if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.
- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.
- Those for care furnished mainly to provide a surrounding free from exposure that can

worsen the person's disease or injury.

- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.
- Those for services and supplies:

  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

  Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)
- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

  Improve the function of a part of the body that:

  is not a tooth or structure that supports the teeth; and
  is malformed:

  as a result of a severe birth defect; including harelip, webbed fingers, or toes; or
  as a direct result of:

  disease; or
  surgery performed to treat a disease or injury.

  Repair an injury. Surgery must be performed:

  in the calendar year of the accident which causes the injury; or
  in the next calendar year.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:

  sildenafil citrate;
  phentolamine;
  apomorphine;
  alprostadil; or
  any other drug that

  is in a similar or identical class,
  has a similar or identical mode of action or exhibits similar or identical outcomes.

  This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in this

Booklet.

- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in this Booklet.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in this Booklet.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for the reversal of a sterilization procedure.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

Coordination of Benefits

Other Plans Not Including Medicare

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

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

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

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

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

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

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

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

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

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

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

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

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

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

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

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

   If the other plan does not have a provision:

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

   then the above paragraph will not apply.

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

If the other plan does not have a provision:

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

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claims transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. A "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules.

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

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

Other Plan

This means any other plan of health expense coverage under:

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

TRICARE

- Tricare is primary for Active Duty Service Members who are covered by the DOD NAF Health Benefit Plan.
- Tricare is secondary to the DOD NAF Health Benefit Plan for Active Duty Family Members, Retirees and/or their Family Members.

Coordination of Benefits Examples

The following information is provided to help clarify specific situations which may arise in the coordination of benefits when a person is covered under more than one plan.

Example One

A female employee works for a NAF employer and is covered under the DOD sponsored medical plan. She elects family coverage, and enrolls her husband as a dependent. At the same time, her husband works for a different employer (other than any branch of the US armed forces) and also elects family coverage under *his* employer sponsored medical plan. He names his wife as a dependent under such plan.

For the medical care of the female NAF employee the DOD sponsored medical plan of benefits will be considered primary. Her husband's plan (under which she is a dependent) would be considered secondary.

For the medical care of the husband, his employer's plan of benefits (under which he is covered as an employee) would be considered primary. The DOD sponsored medical plan of benefits would be considered secondary.

Example Two

If a retiree of a NAF employer:

- has post-retirement medical coverage under the DOD sponsored medical plan; and
- is also eligible for post-retirement coverage under another employer's medical plan (provided that the employer is not a branch of the US armed forces); and
- the same person is covered as a dependent spouse under a Tricare (military) plan;

For the medical care of a retiree who meets the conditions above, the plan of benefits considered to be primary will be either the DOD sponsored medical plan, or the plan sponsored by the person's other former employer. The plan in which the person has been enrolled for a greater length of time will be considered the primary plan.

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

If you are in an Eligible Class and have chosen coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Health Expense Coverage on the date of your coverage under such HMO Plan.

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

- Live in an HMO Plan enrollment area and choose to change coverage during a plan selection or an open enrollment period, coverage will take effect on the first day of the contract period which follows the plan selection or open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when your Employer gives written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when Aetna receives notice of acceptance from your Employer.

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

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

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

Effect of Prior Coverage

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan. It must have been sponsored by a NAF employer. The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

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

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare (Part A and Part B)" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare (Part A and Part B) benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.

- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

DOD NAF Health Benefits Plan Primary to Medicare

Federal law requires that plan benefits for certain covered individuals will be payable before any benefits available through Medicare. Medicare's benefits, if any, will be secondary to this Plan. ***Federal law applies to the following individuals:***

- an active employee regardless of age,
- a totally disabled employee who:
  is not terminated or retired; or
  is not receiving Social Security retirement or Social Security disability benefits,
- a dependent wife or husband, who is eligible for Medicare, of an active employee or a totally disabled employee if not terminated or retired, and
- any other covered individual for whom this Plan's benefits are payable because of compliance with such Federal law.

If this Plan is the primary coverage, Aetna will determine the benefits payable without considering the benefits for Medicare.

For any individual eligible for Medicare due to End Stage Renal Disease (ESRD), the Uniform plan will be considered to be the primary plan of benefits for the first 30 months of a person's entitlement. Such plan benefits will be payable before any benefits available through Medicare. Medicare will become primary beginning with the 31st month of entitlement due to ESRD.

DOD NAF Health Benefits Plan Secondary to Medicare

A Medicare *(Government Exclusion)* approach is applicable to persons listed below who are eligible for Medicare:

- a retired employee,
- a totally disabled employee who:
  is terminated or retired; or
  is receiving Social Security retirement or Social Security disability benefits,
- a dependent, who is eligible for Medicare, of a retired employee or totally disabled employee who is terminated or retired, and
- any other covered dependent for whom this Plan's benefits are payable because of compliance with Federal law.

NOTE: When the Plan is secondary to Medicare, coverage will be provided under the provisions of the Traditional Choice Plan.

Under this Government Exclusion approach, this is how your Comprehensive Medical Expense Coverage changes if you are eligible for Medicare:

1. All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.

2. Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

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

4. Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

5. A participant, otherwise eligible for Medicare, who is unable to receive the benefits of Medicare while residing outside the U.S., the Commonwealth of Puerto Rico, the Virgin Islands, Guam or American Samoa, will be entitled to medical expense benefits without reduction for Medicare. This provision only applies to your medical treatment performed outside the U.S. If you reside outside the U.S. or a territory, you should participate in Part B of Medicare. If you receive medical treatment in the U.S. this plan's benefits will be reduced as if you were enrolled in Part B.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases. Ceasing active work will be deemed to be cessation of employment.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

If you are not at work due to disease, injury, temporary lay-off or leave of absence your employment may be continued until stopped by your Employer.

If you cease active work, ask your Employer if any coverage can be continued.

Dependents Coverage Only

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

- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

Continuation of Coverage For Surviving Dependents

If you die as an active employee covered under any part of this Plan, and had completed a minimum of 90 days of participation in the Department of Defense Nonappropriated Fund Health Benefits Program, and if your dependents are enrolled as a dependent in the Plan on the day of your death, any Health Expense Coverage then in force for your dependents will be continued at no cost to them, for the first four months following your death.

If at the time of your death you had completed a minimum of 90 days, but less than 15 years of participation in the Department of Defense Nonappropriated Fund Health Benefits Program or were not participating in your Employer's defined benefit retirement plan, your covered dependents, including your spouse, will be eligible for up to 36 months of medical coverage through the Temporary Continuation of Coverage Program described on pages 68-71 of this booklet. Four months of this coverage will be paid by your Employer. At the end of the four month period following your death, this coverage is available to your dependents at a cost of 102% of the total employer and employee premium.

If at the time of your death you had completed 15 or more years of participation in the Department of Defense Nonappropriated Fund Health Benefits Program, and were participating in an applicable defined benefit retirement plan, surviving dependents will, following the four months of employer-paid coverage, be required to make contributions toward the cost of their coverage equal to the contributions then being charged to active employees for like coverage. Coverage for your spouse will continue indefinitely, regardless of remarriage. Dependents acquired by your surviving spouse upon remarriage are precluded from coverage.

Under the above sections, any dependents' coverage (other than coverage for your spouse) will cease when any one of the following happens:

- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for like coverage under this Plan.

If Health Expense Coverage is being continued for your dependents, your child born after your death will also be covered. The completed enrollment form must be returned to your Human Resources Manager within 31 days of the date the child is born.

Proof of claim may be given by your spouse or by the custodial guardian of a minor child. Benefits will be paid to the person providing the proof.

Children With Disabilities

Health Expense Coverage for your fully handicapped child may be continued past the maximum age for a dependent child if the child has not been issued a personal medical conversion policy.

Your child is fully handicapped if:

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

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

Coverage will cease on the first to occur of:

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

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

Conversion of Medical Expense Coverage

This Plan permits certain persons whose Medical Expense Coverage has ceased to convert to a personal medical policy if you have been covered under this Plan for at least 3 months. No medical exam is needed. You and your family members may convert when all coverage ceases because your employment ceases or you cease to be in an eligible class. You may not convert if coverage ceases because the group contract has discontinued as to your medical coverage.

The personal policy may cover:

- you only; or
- you and all of your family members who are covered under this Plan when your coverage ceases; or
- if you die before you retire, all your family members, or your spouse only, who are covered under this Plan when your coverage ceases.

Also, if your own coverage continues, your dependents can apply if they cease to be a dependent as defined in this Plan.

You may convert when you become a retired employee. Conversion to a personal policy is not necessary if you qualify for continued Medical Expense Coverage after you retire. If you choose to continue Medical Expense Coverage after you retire, this conversion privilege will not again be available to you.

The personal policy must be applied for within 31 days after coverage ceases or would otherwise cease without a provision to continue coverage for retired employees. The 31 days start on the date coverage actually ceases even if the person is still eligible for benefits because the person is totally disabled.

Aetna may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:

  any other hospital or surgical expense insurance policy;

  any hospital service or medical expense indemnity corporation subscriber contract;

  any other group contract;

  any statute, welfare plan or program;

  and that with the converted policy, would result in overinsurance or match benefits.

No one has the right to convert if you have been covered under this Plan for less than 3 months. Also, no person has the right to convert if:

- he or she becomes eligible for any other Medical Expense Coverage under this Plan.

The personal policy form, and its terms, will be of a type, for group conversion purposes:

- as required by law or regulation; or
- as then offered by Aetna under your Employer's conversion plan.

It will not provide coverage which is the same as coverage under this Plan. The level of coverage may be less and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both of:

- A statement that benefits under it will be cut back by any like benefits payable under this Plan after your coverage ceases.
- A statement that Aetna may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.

The personal policy will state that Aetna has the right to refuse renewal under some conditions. These will be shown in that policy.

If you or your dependent want to convert:

- Ask your Employer for a copy of the "Notice of Conversion Privilege and Request" form.
- Send the completed form to the address shown.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply. If you are residing overseas at that time, you will not be eligible to convert unless you return to the United States within 31 days from the date your coverage under this Plan ceases.

The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be Aetna's normal rate for the person's class and age, and the form and amount of coverage.

The personal policy will take effect on the day after coverage terminates under this Plan.

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

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

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

Assignments

Coverage may be assigned only with the written consent of Aetna.

Recovery of Benefits Paid

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to all rights of recovery a covered person has against any party potentially responsible for making any payment to a covered person due to a covered person's injuries or illness, to the full extent of benefits provided or to be provided by the plan.

In addition, if a covered person receives any payment from any potentially responsible party as a result of an injury or illness, the plan has the right to recover from, and be reimbursed by, the covered person for all amounts this plan has paid and will pay as a result of that injury or illness, up to and including the full amount the covered person receives from all potentially responsible parties. The covered person agrees that if he/she receives any payment from any potentially responsible party as a result of an injury or illness, he/she will serve as a constructive trustee over the funds. Failure to hold such funds in trust will be deemed a breach of the covered person's fiduciary duty to the plan.

Further, the plan will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a covered person receives from a third party, the third party's insurer or any other source as a result of the covered person's injuries. The lien is in the amount of benefits paid by the insurer under this policy for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a covered person due to a covered person's injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage. For purposes of this provision, a covered person includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependant of any plan member or person entitled to receive any benefits from the plan.

The covered person acknowledges that this plan's recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the plan before any other claim for the covered person's damages. This plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the plan will result in a recovery to the covered person which is insufficient to make the covered person whole or to compensate the covered person in part or in whole for the damages sustained. It is further agreed that the plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the covered person to pursue the covered person's damage claim.

The terms of this entire right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgement received by the covered person identifies the medical benefits the plan provided. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The covered person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the covered person to notify the plan within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the covered person. The covered person shall provide all information requested by the plan, the Claims Administrator or its representative including, but not

limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against the covered person.

The covered person shall do nothing to prejudice the plan's recovery rights as herein set forth. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

Recovery of Overpayment

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

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

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

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the medical expense. Your may obtain claim forms through your Employer or through Aetna Member Services.

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

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

Payment of Benefits

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

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

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

Records of Expenses

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

Very important are:

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

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the Plan Document on file with your Employer. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued as to all or any class of employees.

Glossary

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

Board and Room Charges

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

Calendar Year Deductible

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

Companion

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

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

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

  professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and

  physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Copay

This is a fee, charged to a person, which represents a portion of the applicable expense.

As to a **prescription drug** dispensed by a **preferred pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is In no event will the copay be greater than the **prescription** or refill.

It is specified in the Summary of Coverage.

Custodial Care

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

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

Dentist

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

Durable Medical and Surgical Equipment

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

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

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

Effective Treatment of Alcoholism Or Drug Abuse

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Emergency Admission

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

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:

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

Emergency Care

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

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

Emergency Condition

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

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

Family Deductible Limit

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

Home Health Care Agency

This is an agency that:

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

Home Health Care Plan

This is a plan that provides for care and treatment of a disease or injury.
The care and treatment must be:

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

Hospice Care Agency

This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:

  skilled nursing services; and

  medical social services; and

  psychological and dietary counseling.
- Provides or arranges for other services which will include:

  services of a **physician**; and

  physical and occupational therapy; and

  part-time home health aide services which mainly consist of caring for **terminally ill** persons; and

  inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:

  one **physician**; and

  one **R.N.**; and

  one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- Assesses the patient's medical and social needs.
- Develops a **Hospice Care Program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **Hospice Care**, which:

- Is established by and reviewed from time to time by:

  a **physician** attending the person; and

  appropriate personnel of a **Hospice Care Agency**.
- Is designed to provide:

  palliative and supportive care to **terminally ill** persons; and

  supportive care to their families.
- Includes:

  an assessment of the person's medical and social needs; and

  a description of the care to be given to meet those needs.

Hospice Facility

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

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

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N.

This means a licensed practical nurse.

Mental Disorder

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.
- Anorexia nervosa.
- Bulimia nervosa.

For the purposes of benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

NME Patient

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**.

Once an NME Patient is approved by Aetna, the NME Patient will receive written confirmation from Aetna of acceptance into the National Medical Excellence Program.

National Medical Excellence Program ® (NME)

A program that helps approved **NME Patients** access covered treatment for certain organ transplants and other rare or complicated conditions at participating facilities experienced in performing these services.

Necessary

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

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

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

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

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

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

Non-Occupational Disease

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

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

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

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

Non-Occupational Injury

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

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

Non-urgent Admission

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

Orthodontic Treatment

This is any:

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

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

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

whether or not for the purpose of relieving pain.

Not included is:

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

Parent-Child Relationship

A parent-child relationship exists between you and a child when the child is primarily dependent on you for support and the child is:

- unmarried;
- resides in the same household as you;
- has not reached the limiting age of the plan; and
- if school age and regularly attending school, resides primarily in your home.

When a natural parent lives in the same household, a parent-child relationship exists between you and a child only when both the natural parent and the child are primarily dependent upon you for support and the natural parent as well as the child meet the IRS dependency tests.

Physician

This means a legally qualified physician.

R.N.

This means a registered nurse.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

Semiprivate Rate

This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Student

A student is one who;

- attends school regularly on a full-time basis;
- is not employed full-time (working 7-8 hours a day, 5 days a week); and
- attends a school which:

  is an institution which offers a regular schedule of courses on an annual or more frequent basis;

  has a full-time faculty and a permanent administration; and

  includes some formal classroom sessions rather than just on-the-job training.

Surgery Center

This is a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:

  physicians who practice surgery in an area hospital; and

dentists who perform oral surgery.

- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a **R.N.**
- Is equipped and has trained staff to handle medical emergencies.
- It must have:

  a **physician** trained in cardiopulmonary resuscitation; and

  a defibrillator; and

  a tracheotomy set; and

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

Terminally Ill

This is a medical prognosis of 6 months or less to live.

Treatment Facility (Alcoholism Or Drug Abuse)

This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **effective treatment of alcoholism or drug abuse**.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician**.
- Provides, on the premises, 24 hours a day:

  Detoxification services needed with its effective treatment program.

  Infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.

  Supervision by a staff of **physicians**.

  Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

Urgent Admission

One where the **physician** admits the person to the **hospital** due to:

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

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

Temporary Continuation of Coverage Program

Plan participants are eligible for the continuation provision if they are no longer eligible to participate in the Department of Defense Nonappropriated Fund Health Benefits Program (NAF HBP). **This Temporary Continuation of Coverage Program applies to any employee, retiree or dependent who is no longer eligible to participate in the NAF HBP for any reason, other than termination for cause.**

This continuation provision, known as the Temporary Continuation of Coverage Program, is effective January 1, 2000. This program is administered by Aetna. The Temporary Continuation of Coverage Program is not underwritten by Aetna Life Insurance Company.

This program does NOT apply to participants who qualify for continued medical/dental coverage after retirement (that is, they retire upon an immediate annuity and have 15 years participation in the group plan).

Eligible Employees

Active/Retired employees and their dependents are eligible for the Temporary Continuation of Coverage Program provided:

- The employee has been covered under the Department of Defense Nonappropriated Fund Health Benefits Program for at least 90 days prior to the date the person lost coverage;
- The active/retired employee or his/her dependent is not eligible for Medicare;
- The individual was enrolled in the plan on the day preceding the "qualifying event."

Qualifying Event

"Qualifying Event" for the purposes of this continuation provision is defined as follows:

1. Conversion to a non-eligible class.

2. Termination of employment for any reason for any reason other than gross misconduct (separation for cause), or

3. Retirement.

A qualified participant is eligible to continue medical coverage under the Program for a maximum of 18 months from the date the regular plan (plan covering active participants) of medical coverage terminates.

The following information indicates who is eligible for "single" rate coverage and who is eligible for "family" rate coverage. The applicable contribution (premium) rates are indicated.

Continuation of Contributions

General Rules

The single rate will be charged to anyone who wants coverage only for himself/herself and is eligible for that coverage because of their individual status. Otherwise, the family rate will be charged.

Monthly continuation rates for individuals who want to continue their participation in the group medical program are established as follows:

Single Rate

Monthly continuation rates for individuals who want to continue their participation in the group medical program are established to:

1. an employee who previously had single coverage;

2. an employee who previously had family coverage but only wants to cover himself/herself;

3. a spouse OR dependent who was previously covered under the employee's plan but only wants to cover himself/herself when the employee does not want continued coverage;

4. a divorced spouse (only) of an employee who is still covered under the plan;

5. the underage child of a deceased employee. The surviving spouse and any other underage dependent children are not covered;

6. the spouse of a deceased employee, underage children eligible but not covered;

7. a child who reaches the limiting age (19 or up to 25 if he/she is a full-time student) may be covered under a single rate even though a former spouse or surviving spouse is covered under a single rate;

8. a spouse covered under the single rate must change to the family rate in order to cover a newborn child; cannot cover a new dependent other than through birth or adoption.

Single coverage not allowed:

1. Death of employee; spouse and one child could not be individually covered as two singles. (Except as noted under "Single Rate," item 7 above.)

2. Terminated employee; spouses of underage child who both want coverage could not apply for single coverage individually.

3. Terminated employee and spouse could not each apply for single coverage.

Family Rate

Terminated employees who want to cover themselves and:

1. a spouse alone; or

2. a child alone; or

3. children; or

4. a spouse and any number of children; or

5. the spouse of a deceased employee. Spouse wishes self coverage and coverage for any number of children.

Enrollment

An employee has 60 days after the regular plan of medical coverage terminates to enroll in the Program. You must enroll in the plan that is determined by your place of residence.

Adjustments

Contribution rates will be adjusted at the same time that active employee contribution rates are adjusted.

Conversion

Participants may convert to an individual policy with Aetna, either at the point of termination of employment or later, at the end of the 18-month continuation period. The participant will be notified of the conversion privilege closer to the end of the continuation period.

Termination Provisions

The Program will discontinue as to a participant at the earliest to occur of the following:

- When the participant fails to make required contributions by the due date;
- When the participant becomes eligible for Medicare benefits;
- When the participant becomes eligible under another group coverage medical plan. An exception is made if the new plan contains pre-existing conditions which limit coverage.
- When the participant again becomes eligible for the regular plan of Medical Expense Coverage.
- When the 18 months has elapsed since the participant's regular coverage terminated (36 months for surviving dependents or disabled employees).
- When the plan terminates.

Additional Information

The Temporary Continuation of Coverage Program is NOT the same as the Conversion of Medical Expense Coverage Privilege. The major differences between the two programs are shown next. See the individual sections for details on eligibility.

The Conversion Privilege allows eligible participants to convert to an INDIVIDUAL medical expense policy *without medical examination*. This coverage is not the same as that provided under the group plan.

The Temporary Continuation of Coverage Program applies to eligible participants who are allowed to "continue" in the GROUP Medical Plan but who pay 102% of the combined Employer/participant contribution rate for whichever continuation plan is selected. *Dental Expense Coverage is NOT included.* The Temporary Continuation Program is available worldwide. Single and Family rates are available based on the criteria established in this section.

The 18-month continuation period does not apply to persons who are eligible for Medicare.

Participation in this program will not count toward accumulated active participation in the plan or qualification for retiree coverage.

Temporary Continuation of Coverage for Employees who are Totally Disabled

Employees who are totally disabled when their NAF HBP medical coverage ends will be eligible for continuation of medical coverage for up to 36 months from the date medical coverage ends. The cost of this medical coverage depends on the length of time covered under the Plan. Employees in the Plan for less than 5 years pay 102% for 36 months of coverage, including dependents. Employees in the Plan for 5 or more years will be covered for 12 months with no payment of premiums, then will pay 102% for the next 24 months, including dependents.

The words "totally disabled" mean that due to injury or disease, you are not able to engage in your customary occupation and are not working for pay or profit.

To be eligible for temporary continuation of coverage under the Health Expense Coverage disability provisions, the employee's attending physician must provide evidence of the disability to the employee's Human Resources Office (HRO) *. You must submit a doctor's statement as proof of total disability within 60 days of the date your medical coverage first terminated.

*Army Air Force Exchange Service employee's attending physician must provide evidence of the disability to Aetna.

The temporary disability coverage for the employee and dependents will cease to apply when the first of the following occurs:

- The employee ceases to be totally disabled.
- The employee becomes eligible for Medicare.
- The employee becomes eligible under another group coverage medical plan. An exception is made if the new plan contains pre-existing conditions which limit coverage.
- The employee fails to make required contributions by the due date.
- When 36 months has elapsed since the employee's regular DOD NAF HBP coverage ended.
- The plan terminates.

Claims Appeals For Health Expense Benefits

Claim Procedures for Health Expense Benefits

This booklet contains information on reporting claims. Claim forms may be obtained at your place of employment or through Aetna. These forms tell you how and when to file a claim.

Benefits under this plan will be paid only if the plan administrator decides in his/her discretion that the applicant is entitled to them.

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

Filing Health Claims under the Plan

You or your authorized representative may file claims for Plan benefits, and appeal adverse claim decisions. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Urgent Care Claim

"Urgent Care" means services received for a sudden illness, injury or condition that is not an emergency condition but requires immediate outpatient medical care that cannot be postponed.

If the Plan requires advance approval of a service, supply or procedure before a benefit is payable and it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received. If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Pre-Service Claim

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

Post-Service Claims

For all other claims, you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended

up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period and advised of any additional information that is needed to process the appeal. You will be notified of the Plan's claim decision no later than 15 days after receipt of the necessary information or the end of 45 days, whichever is earlier.

Filing an Appeal of an Adverse Benefit Determination

Level I Appeal

You have the right to file an appeal of an adverse benefit determination. An appeal must be received within one hundred and eighty (180) calendar days of notification of an adverse benefit determination in order to be considered. Aetna will notify you of the appeal decision in the following timeframes:

Urgent Care Claim – 36 hours
Pre-Service Claim – 15 days
Post-Service Claim – 30 Days

Level II Appeal

If you are dissatisfied with the level I appeal decision, you have the right to file a level II appeal. You have 60 days to submit an appeal of the Level I decision. Aetna will notify you of the appeal decision in the following timeframes:

Urgent Care Claim – 36 hours
Pre-Service Claim – 15 days
Post-Service Claim – 30 Days

Appeal to the Plan Sponsor After Level I and Level II Appeals

The member has 30 days to submit an appeal to the Plan Sponsor. The Plan Sponsor has final authority after Level I and Level II Appeals to Aetna have been exhausted.

This information is provided to you by your employer. This claim appeal information is being provided as an aid to you in keeping claim material related to health coverage together. If you have any questions or problems, please call the 800 number on your ID card.