Aetna Hospital Plan℠

What Your Plan Covers and How Benefits are Paid

Prepared Exclusively For
Toys"R"Us, Inc.

Hospital Indemnity Plan

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

ATTENTION FLORIDA RESIDENTS: THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

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Your Group Coverage Plan

This Plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (called **Aetna**). The benefits and main points of the group contract for persons covered under this Plan are set forth in this *Booklet-Certificate*. They are effective only while you are covered under the group contract.

If you become covered, this *Booklet-Certificate* will become your *Certificate of Coverage*. It replaces and supersedes all Certificates issued to you by **Aetna** under the group contract.

This *Booklet-Certificate* is subject to the laws of the state of New Jersey.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Cert. Base: 1
Issue Date: April 22, 2016
Effective Date: July 1, 2016

Important Note

The Aetna Hospital Plan is a hospital confinement indemnity plan. This plan provides limited benefits. It pays fixed daily dollar benefits for covered services without regard to the health care provider's actual charges. The benefit payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have.

This Plan does not count as minimum essential coverage under the Affordable Care Act.

General Conditions for Coverage

To receive a benefit payment under the plan **stays** must meet all of the following requirements:

1. They must be covered by the plan. For a **stay** to be covered, it must:

   - Be included as covered in this *Booklet-Certificate*;
   - Not be excluded under this *Booklet-Certificate*. Refer to the *General Exclusions* section of this *Booklet-Certificate* for a list of services and supplies that are excluded;
   - Not exceed the maximums outlined in this *Booklet-Certificate*. Refer to the *Summary of Coverage* for information about day, visit and service limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this *Booklet-Certificate*.

2. The **stay** must be provided while coverage is in effect. See the *Eligibility* section of the *Summary of Coverage* and the *Termination of Coverage* section of the *Booklet-Certificate* for details on when coverage begins and ends.

3. The **stay** must be **necessary**.

Facility Indemnity Plan

These benefits will apply to you and your insured dependents if they are elected by the employer and described in the *Summary of Coverage*.

This Plan will pay the applicable *Inpatient Indemnity Benefit* described below for each **hospital, rehabilitation facility, hospice facility,** or **skilled nursing facility stay** of an insured person if:

- The **stay** is due to labor and delivery or treatment of an injury or illness;
- It begins while the insured person is insured for this Facility Indemnity coverage; and
- It is advised by a **physician**.

The **intensive care unit (ICU)** is a section within a **hospital** which is operated solely for critically ill patients. It must provide: special supplies; equipment; and constant observation and care by an **R.N**. or other highly trained **hospital** personnel. It does not include any **hospital** facility maintained for the purpose of providing normal post-operative recovery treatment or services.

The *Summary of Coverage* shows the Benefit and the associated maximums for each of the inpatient benefits described in the *Inpatient Indemnity Benefit* section.

Inpatient Indemnity Benefits

An Initial Day and Daily Benefit after the initial day will be paid for any of the following:

- Private and Semi-Private Board & Room for each day of **stay** in a **hospital**, **treatment facility**, **rehabilitation facility**, **hospice facility**, or **skilled nursing facility**.
- For **stays** in an **intensive care unit**.

General Exclusions

No benefit is paid for, or in connection with, the following **stays**:

- Those not **necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed, recommended, or approved by the attending **physician**.
- Those that are not prescribed, recommended, and approved by the person's attending **physician**.
- Those received outside the United States.
- Those for **experimental or investigational** procedures, as determined by **Aetna.**
- Those for services of a resident **physician** or intern rendered in that capacity
- Those that an insured person is not legally obliged to pay.
- Those, as determined by **Aetna**, to be for **custodial care**.
- Those for education, special education or job training, whether or not given in a facility that also provides medical or psychiatric treatment.
- Those in connection with 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;
    - is malformed:
      1. as a result of a severe birth defect; this includes cleft lip/palate or webbed fingers or toes;
      2. as a direct result of **illness**; or surgery performed to treat an **illnes**s or **injury**.
  - Repair an **injury** which occurs while the person is covered under this Plan. Surgery must be performed:
    - in the **coverage year** of the accident which causes the injury; or
    - in the next **coverage year**.
- Those to treat an **illness** or **injury** sustained while flying as a pilot or crew member of any aircraft or travel or flight. This includes boarding or alighting in any vehicle or device while being used for any test or experimental purposes or while being operated by; for; or under; the direction of any military authority other than the Military Airlift Command of the United States or similar air transport service of any other country.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.

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- Those resulting from an **injury** or **illness** due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
- Those for private duty nursing.
- Those to treat an **injury** sustained while the insured person was legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the **injury** occurred.
- Those to treat an **injury** sustained while the insured person was voluntarily using any drug, narcotic or controlled substance unless as prescribed by a **physician**.
- Those for visits by a **physician** for non-surgical medical treatment given to a person during a **stay** in a **hospital, treatment facility, rehabilitation facility, hospice facility** or **skilled nursing facility**. This includes consultation services given to an insured person while confined as an inpatient in such facility. A "consultation" is an exam of the person; a review of his or her x-ray and lab exams; a review of the person's medical history; and a written report by the consulting **physician** if the attending **physician** requests one.

Any exclusion above will not apply to the extent that a benefit is specifically provided elsewhere in this Policy.

These excluded services will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Coordination of Benefits

This Plan does not coordinate benefits with any other plan.

General Information About Your Coverage

Termination of Coverage

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

- When your employment ceases.
- 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 by the premium due date, subject to the grace period.

Your employer will notify **Aetna** of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next premium due date following the date you cease active work. Your employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to **illness** or **injury**, your employment may be continued until stopped by your employer but not beyond 30 months from the start of the absence, for coverage.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your employer.

In figuring when employment will stop for the purposes of termination of any coverage, **Aetna** will rely upon your employer to notify **Aetna**. This can be done by telling **Aetna** or by stopping premium payments. Your employment may be deemed to continue beyond any limits shown above if **Aetna** and your employer so agree in writing.

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

Termination of Coverage for Dependents

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

a) Termination of all dependents' coverage under the group contract;
b) When a dependent becomes covered as an employee;
c) When such person is no longer a defined dependent; or
d) When your coverage terminates.

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

a) When this Plan no longer allows coverage for domestic partners; or
b) The date of termination of the domestic partnership. In that event, you should provide your Employer with a completed and signed Declaration of Termination of Domestic Partnership.

You may obtain the form from your Employer or by calling Member Services toll-free number on your I.D card.

Continuation of Coverage for Your Dependents

If you die while covered under any part of this Plan, any coverage then in force for your dependents will be continued. But your **employer** must continue to make premium payments.

Your spouse's coverage will cease, when your spouse remarries. Your domestic or civil union partner's coverage will cease the date he or she enters into another domestic partner relationship or civil union partnership. Any dependent's coverage, including your spouse's or domestic or civil union partner's, will cease when any one of the following happens:

a) The end of the 12 month period right after your death.
b) A dependent ceases to be a defined dependent.
c) A dependent becomes eligible for like coverage under this Plan.
d) Dependent coverage ceases as to the Eligible Class of which you were a member right before your death.
e) Any required contributions cease.

If coverage is being continued for your dependents, your child born after your death will also be covered.

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.

Handicapped Dependent Children

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

Your child is fully handicapped if:

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

Facility Indemnity Benefits After Termination

If a person is totally disabled when his or her Facility Indemnity Coverage ceases, benefits will be available to him or her while disabled until the earliest of the following to occur:

- The person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.);
- The day the disability ends;
- The 90th day after the covered person's coverage ends; or
- The end of the maximum benefit period.

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.
- Your dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

Type of Coverage

Coverage under this Plan for benefits is non-occupational. Only **non-occupational accidental injuries** and **non-occupational illnesses** are covered. Coverage for a **stay** is provided only if it begins after the insured person is covered for the Plan's benefits.

Legal Action

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

Additional Provisions

The following additional provision applies to your coverage.

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 group contract. 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 or, if you prefer, from the Home Office of **Aetna**.

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

Assignments of Your Coverage

Coverage may not be assigned. An assignment is the transfer of your rights under the *Booklet-Certificate* to a person you name.

Although you may not transfer your rights under this *Booklet-Certificate* to another person, you may request to have benefits paid directly to your service provider instead of you.

Reporting of Claims

Written notice of a claim must be submitted to **Aetna** within 20 days after the date in which the **stay** occurred. Any necessary claim forms required for filing a claim will be furnished by **Aetna** upon receipt of written request. Failure to give notice of loss shall not invalidate nor reduce any claim if notice was given as soon as reasonably possible. Written proof of loss must be furnished to **Aetna** within 90 days after the date of such loss. If the person making claim does not receive the requested claim forms before the expiration of 15 days after **Aetna** receives notice of any claim, the person making such claim shall be deemed to have complied with the requirements of the plan as to proof of loss upon submitting within the time fixed within the plan for filing proof of loss, written proof covering the **occurrence**, character and extent of the loss for which claim is made.

For claims filed by a provider on your behalf, the provider shall file with **Aetna** the claim within 60 days of the last date of service or course of treatment. For claims in which you have assigned your benefits to the provider, the provider shall file the claim within 180 days of the last date of service of a course of treatment. In the event the provider does not file the claim within 180 days of the last date of the **stay**, **Aetna** reserves the right to deny or dispute the claim and the provider shall be prohibited from seeking payment in whole or in part directly from you.

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. Failure to furnish such proof within such time shall not reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible.

Payment of Benefits

(1) Upon satisfactory proof of loss, **Aetna** will remit payment for claims submitted by [you] or [your] provider no later than 30 calendar days following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program, whichever is earlier, if the claim is submitted by electronic means and no later than 40 calendar days following receipt if the claim in submitted by other than electronic means, if:

- the health care provider is eligible at the date the **stay** began;
- the person who was confined during the **stay** was covered on the date the **stay** began;
- the claim is for a **stay** covered under the policy;
- the claim is submitted with all the information requested by **Aetna** on the claim form or in other instructions that were distributed in advance to the provider or member in accordance with New Jersey laws; and
- **Aetna** has no reason to believe that the claim has been submitted fraudulently.

(2) If all or a portion of the claim is not paid within the timeframes provide above because:

- The claim submission is incomplete because the required substantiating documentation has not been submitted to **Aetna**;
- The diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
- **Aetna** disputes the amount claimed; or

- There is strong evidence of fraud by the provider and **Aetna** has initiated an investigation into the suspected fraud, **Aetna** shall notify the provider, by electronic means and you in writing within 30 days of receiving an electronic claim, or notify you and provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:
  - The claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim;
  - The claim contains incorrect information with a statement as to what information must be corrected for adjudication of the claim;
  - **Aetna** disputes the amount claimed in whole or in part with a statement as to the basis of what dispute; or
  - **Aetna** finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with **Aetna**'s fraud prevention plan, or referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

(3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, **Aetna** shall electronically notify the provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.

(4) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by **Aetna** in accordance with the time limit established in paragraph (1) of this subsection.

(5) **Aetna** shall acknowledge receipt of a claim submitted by electronic means from a health care provider no later than two working days following receipt of the transmission of the claim.

(6) If **Aetna** has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan, or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

(7) Payment of an eligible claim pursuant to paragraphs (1) and (4) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by **Aetna** on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by **Aetna** of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

If payment is withheld on all or a portion of a claim by **Aetna** pursuant to subparagraph (a) or (b) of paragraph (2) or paragraph (3) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by **Aetna** on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by **Aetna** of the required documentation or information or modification of an initial submission.

If payment is withheld on all or a portion of a claim by **Aetna** pursuant to paragraph (2) or (3) of this subsection and the covered person and the provider are not notified within the time frames provided for in those paragraphs, the claim shall be deemed to be overdue.

Any overdue payment shall bear simple interest at the rate of 12% per annum. **Aetna** shall pay the interest to the provider at the time the overdue payment is made. The amount of interest paid to a provider for an overdue claim shall be credited to any civil penalty for late payment of the claim levied by the Department of Human Services against a payer that does not reserve the right to change the premium.

Acknowledgement of receipt of claims

(a) **Aetna** shall acknowledge receipt of all claims. The acknowledgement shall include the date **Aetna** received the claim.

1. If a claim is submitted by electronic means, the claim shall be acknowledged electronically no later than two working days following receipt of the claim. The acknowledgement of receipt of an electronic claim shall go to the entity from which **Aetna** received the claim.

2. If a claim is submitted by written notice, the claim shall be acknowledged no later than 15 working days following receipt of the claim.

(b) If **Aetna** remits payment within two working days of receipt of a claim submitted electronically, or 15 working days of receipt of a claim submitted by written notice, and such payment includes the date of receipt of the claim, the payment shall constitute acknowledgement of receipt.

(c) If **Aetna** offers providers web-based access to claims status, the available information shall include the date of receipt of the claims. Such information, if posted within the timelines established in (a) 2 above, shall constitute acknowledgement of receipt of those claims.

(d) If **Aetna** offers providers access to claims status via an automated telephone system, and the available information includes the date of receipt of the claims, and that information is made available within the timelines established in (a) 2 above, the posting of that information shall constitute acknowledgement of receipt of those claims

All benefits are payable to you, except that, at the request of the employee or insured person or in the event of his/her death, payment of benefits on account of hospitalization may be made by **Aetna** to the **hospital** or other facility and except that the policy may provide that all or any portion of any benefits on account of any **stay** may, at **Aetna**'s option, be paid directly to the **hospital** or other facility provided, further, that authorization for any such payments have been obtained from the insured person.

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

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 services are provided.
- Copies of all bills and receipts.

Effect of Other Coverage

Any Basic, Major Medical, Comprehensive Medical or Prescription Drug or Comprehensive Dental Expense Benefits provided under other coverage will not affect Facility Indemnity benefits payable under this *Booklet-Certificate*. Benefits payable under this *Booklet-Certificate* are not coordinated with benefits payable under any other *Booklet-Certificate* or program.

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 the benefit section and also appears in the *Glossary* section, the definition in the benefit section will apply in lieu of the definition in the *Glossary* section.

Accident

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

Aetna

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

Coverage Year

This is the period during which benefit maximums accumulate. Each new **coverage year**, these maximums reset.

Creditable Coverage

A person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care

This means services and supplies that are primarily intended to help an insured person meet their personal needs. Care can be custodial even if it is prescribed by a **physician**, delivered by trained medical personnel, or even if it involves artificial methods (or equipment) such as feeding tubes, monitors, or catheters. **Custodial Care** includes; but is not limited to; the following services:

- Changing dressings and bandages; periodic turning and positioning in bed; administering oral medication; watching or protecting an insured person;
- Care of a stable tracheostomy (this includes intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or constant) feeding;
- Care of a stable indwelling bladder catheter (this includes emptying/changing containers and clamping tubing);
- Respite care; adult (or child) day care; or convalescent care;

- Helping an insured person perform an activity of daily living, such as: walking; grooming; bathing; dressing; getting in and out of bed; toileting; eating or preparing food; and
- Any services that an insured person without medical or paramedical training can perform or be trained to perform.

Civil Union Partner

A person who has established a civil union as defined by New Jersey State Law. If applicable, any references under this Booklet-Certificate made to "marriage", "husband", "wife", "family", "immediate family", "dependent", "next of kin", "widow", "widower", "widowed" or another word which in a specific context denotes a marital or spousal relationship, the same shall include a **civil union partner**. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another jurisdiction or foreign nation that provides substantially all of the rights and benefits of marriage shall be treated as a **civil union partner** under New Jersey law.

Dentist

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

Experimental or Investigational

A drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is **experimental or investigational**, or for research purposes.

Hospice Facility

This is a facility, or distinct part of one, which mainly provides inpatient hospice care to **terminally ill** persons, charges its patients and meets any licensing or certification standards set forth by the jurisdiction where it is located.

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; and
- Makes charges.

Illness

This means a pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury
This means a bodily **injury** that is solely and directly a result of an **accident**. An accidental bodily **injury**.

Intensive Care Unit
This is a designated ward, unit, or area within a **hospital** for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such **hospital**.

Late Enrollee
This is an employee in an Eligible Class who requests enrollment under the Plan after you first become eligible to enroll. In addition, this is an eligible dependent for whom the employee did not elect coverage when you first became eligible to enroll, but for whom coverage is elected at a later time.

However, an eligible **employee** or dependent may not be considered a **late enrollee** under certain circumstances. See the *Late Enrollee* and *Exceptions* sections of the *Summary of Coverage*.

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**, psychologist or a psychiatric social worker. A **mental disorder** includes; but is not limited to:

- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Psychotic depression.
- Schizophrenia.
- **Substance abuse**.

Necessary
This means 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 **illness** 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; and
- 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 **illness** or **injury** involved and the person's overall health condition.

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 **illness** or **injury** could safely and adequately be diagnosed or treated while not confined.

Non-Occupational Injury

This 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-Occupational Illness

This is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of Workers' Compensation law; and
- Is not covered for that **illness** under such law.

Occurrence

This is a period of **illness** or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the insured person:

- Receives no medical treatment; services; or supplies; for an **illness** or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for an **illness** or **injury**.

Physician

A duly licensed member of a medical profession who:

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

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;

- Under applicable insurance law, is considered a "**physician**" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by **substance abuse** or a **mental disorder**; and
- A **physician** is not you or related to you.

Psychiatrist

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of **mental disorders**.

R.N.

This means a registered nurse. This also includes coverage for the services of a licensed midwife, a certified nurse anesthetist designated as a certified registered nurse anesthetist by the board of nurse registration and nursing education.

Rehabilitation Facility

This means a comprehensive free-standing facility which provides rehabilitative services**.** Rehabilitative services are the combined and coordinated use of medical; social; educational; and vocational measures: for training or retraining insured persons disabled by **illness** or **injury**.

Skilled Nursing Facility

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

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an **R**.**N**., or by an **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**.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law; and
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons**.**
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities.

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or rehabilitation services.

Skilled nursing facility does not include:

- Institutions which provide only:
- Minimal care;
- **Custodial care services**;
- Ambulatory; or
- Part-time care services.
- Institutions which primarily provide for the care and treatment of a **mental disorder** or **substance abuse**.

Skilled Nursing Services

This means services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N**. or **L.P.N**. within the scope of his or her license.
- The services are not custodial.

Stay

This means a period during which an insured person is confined as an inpatient in a **hospital**, **treatment facility**, **hospice facility**, **skilled nursing facility**, or **rehabilitation facility**. **Stay** does not include any period of such a confinement due to **custodial care** or personal needs that do not require medical skills or training. A **stay** excludes time in the **hospital** for observation or in the emergency room unless this leads to a **stay.** Two or more separate **stays** count as one **stay** if: (a) they are due to the same or related **illness** or **injury**; and (b) they are separated by less than 90 days. Otherwise they count as separate **stays**. In addition, in determining a period of continuous confinement, a **stay** for an **injury** shall not be combined with a **stay** for an **illness** regardless of whether the **illness** is related or unrelated to the **injury**.

Substance Abuse

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

Terminally Ill

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

Treatment Facility (Substance Abuse)

This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and effective treatment of **substance abuse**.
- 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 services** by licensed nurses who are directed by a full-time **R.N**

Treatment Facility (Mental Disorder)

This is an institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatrist** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatrist** involved in care and treatment.
- Has a **psychiatrist** present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatrist**.
- Meets licensing standards.

Confidentiality Notice

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

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

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

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

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

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

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Indemnity Benefits for you and your eligible dependents. Your Employer may also allow you to continue other coverage for which you are covered under the group contract on the day before the approved FMLA leave starts.

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

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

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

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

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

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

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

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

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

Employer: Toys"R"Us, Inc.

Group Policy No.: GP-802234

Effective Date: July 1, 2016

The group policy noted above has been amended. The following summarizes the changes in the group policy and the *Booklet-Certificate*, describing the policy terms, is amended accordingly. This amendment is effective on the date shown above.

The following Appeals Procedure, Exhaustion of Process and External Review provisions are added to your *Booklet-Certificate*:

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **necessary**.

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

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

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

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

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. If **Aetna** makes an **adverse benefit determination**, written notice will be provided to you. Your authorized representative or a **provider** acting on your behalf must be given written notice of any **adverse benefit determination** within two business days of the **adverse benefit determination**. The written notice must include an explanation of the Appeals Process.

Post-Service Claims

Aetna will notify you of a post-service claim decision as soon as possible, but not later than 30 calendar days after the claim is made or the time limit established by Medicare, if earlier, after the **post-service claim** is made if the claim is submitted electronically, or 40 days, if submitted by a means other than electronic.. **Aetna** may determine that due to matters beyond its control a claim may require special treatment. If so, **Aetna** will notify you in writing including the reason for delay within 30 days. If special treatment is needed because **Aetna** needs additional information to make a decision, the notice shall specifically describe the required information. In the event that payment is withheld on all or a portion of the claim, because the claim required special treatment, a claim determination will be made on the withheld portion no later than 30 calendar days or the time limit established by Medicare, if earlier, following receipt of the required documentation for claims submitted by electronic means and no later than 40 days following receipt of the required documentation for claims submitted other than electronically.

Complaints

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

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level of **appeal**. A **final adverse benefit determination** notice will also provide an option to request an **External Review.**

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

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

Send your written **appeal** to the address shown on the notice of **adverse benefit determination**, or you may call in your **appeal** using the telephone number listed on the notice.

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

Appeal

A review of an **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Post-Service Claims

Aetna shall issue a decision within 25 calendar days of receipt of the request for an **appeal**.

Please Read:
You may contact the New Jersey Department of Banking and Insurance to file a **complaint/appeal** or request an investigation of a **complaint/appeal** at any time. You are not required to exhaust the **appeals** process before contacting the New Jersey Department of Banking and Insurance.

New Jersey Department of Banking and Insurance
Office of Managed Care
Consumer Protection Services
P. O. Box 329
Trenton, NJ 08625-0329

Before filing an **appeal** with **Aetna**, you or your authorized representative, may also contact the New Jersey Office of Insurance Claims Ombudsman if you are dissatisfied with the decision reached by **Aetna.**

Office of Insurance Claims Ombudsman
Department of Banking and Insurance
P.O. Box 472
Trenton, NJ 08625-0472
Phone: 800-446-7467
Email: ombudsman@dobi.state.nj.us

External Review

You may receive an **adverse benefit determination** or **final adverse benefit determination** because **Aetna** determines that:

- the care is not **necessary**; or
- a service, supply or treatment is **experimental or investigational** in nature.

In these situations, you may request an **External Review** if you or your provider disagrees with **Aetna's** decision.

To request an **External Review**, any of the following requirements must be met:

- You have received a **final adverse benefit determination** notice of the denial of the claim by **Aetna**.
- Your claim was denied because **Aetna** determined that the care was not **necessary** or was **experimental or investigational**.

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from **Aetna** will describe the process to follow if you wish to pursue an **External Review**, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to **Aetna** within 123 calendar days of the date you received the **adverse benefit determination** or **final adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request.

The request shall be mailed to:

New Jersey Department of Banking and Insurance
Office of Managed Care
Consumer Protection Services
P.O. Box 329
Courier: 20 West State Street
Trenton, New Jersey 08625-0329

The fee for filing an appeal shall be $25.00, payable by check or money order to the New Jersey Department of Banking and Insurance. The filing fee is payable by you. The filing fee shall be refunded if the **final adverse benefit determination** is reversed by the Independent Review Organization (IRO). Upon a determination of financial hardship, the fee may be reduced to $2.00. Financial hardship may be demonstrated by you through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, New Jersey Family Care, General Assistance, SSI, or New Jersey Unemployment Assistance. Annual filing fees for any one covered person shall not exceed $75.00.

Upon receipt of the **appeal**, together with the executed release and the appropriate fee, the New Jersey Department of Banking and Insurance shall immediately assign the **appeal** to an IRO

Upon receipt of the request for **appeal** from the New Jersey Department of Banking and Insurance, the IRO shall conduct a preliminary review of the **appeal** and accept it for processing if it determines that:

- The individual was or is covered by **Aetna**.
- The service which is the subject of the **complaint** or **appeal** reasonably appears to be a covered benefit under the plan.
- You have fully complied with the **appeal** process unless **Aetna** fails to comply with any of the deadlines for completion of the Internal Appeals Process. This will not apply if **Aetna's** violation does not cause and is not likely to cause, prejudice, or harm to you or your provider. **Aetna** must demonstrate that the violation was for good cause or due to matters beyond **Aetna's** control and that the violation occurred in the context of an ongoing good faith exchange between **Aetna**, your authorized representative, and/or provider acting on your behalf and is not reflective of a pattern of non-compliance by **Aetna.**
- You have provided all information required by the IRO and the New Jersey Department of Banking and Insurance to make the preliminary determination including the **appeal** form and a copy of any information provided by **Aetna** regarding its decision to deny, reduce, or terminate the covered benefit, and a fully executed release to obtain any necessary medical records from **Aetna** and any other relevant health care provider.
- You have remitted the required fee to the New Jersey Department of Banking and Insurance.

Upon completion of the preliminary review, the IRO shall immediately notify you and/or provider in writing as to whether the **appeal** has been accepted for processing and if not so accepted, the reasons therefore.

Upon acceptance of the **appeal** for processing, the IRO shall conduct a full review to determine whether, you were deprived of **necessary** covered benefits. In reaching this determination, the IRO shall take into consideration all pertinent medical records, consulting **physician** reports, and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by **Aetna**.

The full review referenced above shall refer all cases for review to an expert **physician** in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the **appeal**. All final decisions of the IRO shall be approved by the medical director of the IRO who shall be a **physician** licensed to practice in New Jersey.

The IRO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 45 calendar days from receipt of all documentation necessary to complete the review. The IRO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IRO shall, prior to the conclusion of the preliminary review, provide written notice to you, to the New Jersey Department of Banking and Insurance, and to **Aetna** setting forth the status of its review and the specific reasons for the delay. If the IRO determines that you were deprived of **necessary** covered benefits, the IRO shall recommend to you, **Aetna**, and the New Jersey Department of Banking and Insurance, the appropriate covered health care services you should receive.

Once the review is complete, **Aetna** will abide by the decision of the IRO except to the extent that other remedies are available to either party under State or Federal law. **Aetna** shall provide benefits (including payment on the claim) pursuant to the IRO's determination without delay even if **Aetna** plans to seek judicial review of the external review decision (unless there is a judicial decision stating otherwise). Within 10 business days of the receipt of the decision of the IRO, **Aetna** must submit a written report to the IRO, your authorized representative, or the provider who made the **appeal** acting on your behalf with your consent and the Department of Banking and Insurance indicating how **Aetna** will implement the IRO's determination.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the IRO to New Jersey's Department of Banking and Insurance. **Aetna** is responsible for the cost of sending its information to the IRO.

For more information about the **external review** process, call the Member Services telephone number shown on your ID card.

This amendment makes no other changes to the *Group Policy* or the *Booklet-Certificate*.

AETNA LIFE INSURANCE COMPANY

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Amendment: New Jersey Complaint and Appeals Health Rider
Issue Date: April 22, 2016