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.

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 constitute comprehensive health coverage (also known as "major medical coverage" and it does not count as minimum essential coverage under the Affordable Care Act.

General Conditions for Coverage

To receive a benefit payment under the plan, services and supplies must meet all of the following requirements:

1. They must be covered by the plan. For a service or supply 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 service or supply 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 service or supply 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 occurs 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 maximum for each of the inpatient benefits described in the *Inpatient Indemnity Benefit* section. The Plan will pay:

- A Daily Benefit for each day of a **stay**; and
- A Lump Sum Benefit.

Inpatient Indemnity Benefits

A Daily Benefit will be paid for any of the following:

- Board & Room for each day of **stay** in a **hospital**, **rehabilitation facility**, **hospice facility** or **skilled nursing facility** not due to a **mental disorder** or **substance abuse**.

A Lump Sum Benefit will be paid in addition to the Daily Benefit for Board and Room.

General Exclusions

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

- 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.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.
- Those for the reversal of a sterilization procedure.
- Those for voluntary termination of pregnancy.
- Those for manipulative (adjustive) treatment or other physical treatment of **spinal subluxation**.

- 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 for **hospice care**, except for services rendered in a **hospice facility**.
- Those for the treatment of **substance abuse** and **mental disorders** in a **hospital** or **treatment facility**.
- 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, 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

If you leave employment to perform service in the uniformed services and reapply for coverage, after release of duty, you shall be reinstated, including all of your family members and dependents previously covered, without any clause or restriction as to a preexisting condition limitation.

Any eligible dependent covered under a fixed indemnity plan who is called to service in the uniformed services and whose coverage under a plan or policy is not maintained during such service, after release and upon application of your employer, shall be reinstated with the group policy or plan without any clause or restriction as to a preexisting condition limitation.

As used here, "service in the uniformed services" means:

- The performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time national guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.
- Service in the armed forces of the United States pursuant to authorization by the United States Congress or presidential proclamation pursuant to the War Powers Resolution.
- State active duty by members of the National Guard who are activated pursuant to a call of the governor of this state or of any other state as provided for by law.

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 but not beyond 30 months from the start of the absence, for coverage.

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.

Aetna shall only be liable for covered benefits rendered after to the termination date if such claim is for an **illness** or condition which was the basis of any prior claim

Termination of Coverage for Dependents

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.

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

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

You may obtain the form from your employer or by calling toll-free 1-888-772-9682.

Continuation of Coverage

If you or your dependents coverage under this plan terminates due to termination of employment or divorce, and your coverage has been in force for a three-month period prior to termination of employment or divorce, coverage may continue for you and your dependents. Your coverage will remain in force until the earliest of:

- 12 months after continuation began;
- the end of the period for which you made a timely contribution;
- the contribution due date following the date you or your dependents become eligible for other group coverage; or
- the date on which this plan is terminated or the group withdraws from the plan.

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
- 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 **illness**:

- 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.

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 **Aetna**'s expense.

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. For information regarding benefits that may be payable to your service provider, see *Payment of Benefits* below.

Reporting of Claims

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. Claim forms may be accessed through http://www.aetna.com/docfind/custom/AVP or your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss that caused 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 and in no event later than one year from the time proof is otherwise required. If you are legally incapacitated, late claims for benefits will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary written proof to support the claim is received. Benefits will be payable not more than 30 days after receipt of proof.

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

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.

Premium Contribution Provisions

This plan requires you or your employer to make premium contribution payments. If payments are made through a payroll deduction with your employer, your employer will forward your payment to **Aetna**. **Aetna** will not pay benefits under this *Booklet-Certificate* in the absence of payment of current premium contributions. Any payment denial is subject to the Appeals Procedure described in this *Booklet-Certificate.*
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Clerical Errors

Aetna will evaluate any claims of administrative or clerical error by **Aetna** or the policyholder and will make exceptions and correction for any errors identified

Appeals Procedure

Definitions
As used in this section, the following terms are defined as shown:

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.

Post-Service Claims

Aetna will notify you of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of no longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

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 within 30 calendar days of the incident. 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**; and
- 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 60 calendar days of receipt of the request for an **appeal**.

Exhaustion of Process

You must exhaust the applicable Appeal Procedure before you:

- Contact the Louisiana Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Louisiana Department of Insurance; or
- Establish any:

    - litigation;
    - arbitration; or
    - administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

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.

Aetna will contact the IRO that will conduct the review of your claim. The IRO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Form*, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the IRO usually within 45 calendar days of receipt of your request form by the IRO and all the necessary information.

Aetna will abide by the decision of the IRO, except where **Aetna** can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the IRO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the IRO and for the cost of the external review.

For more information about the Appeals Procedure or **External Review** processes, call the Member Services telephone number 1-888-772-9682.

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**.

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.

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

Effective Treatment of a Mental Disorder
This is a program that:

- Is prescribed and supervised by a **physician**; and
- Is for a disorder that can be favorably changed.

Effective Treatment of Substance Abuse
This means a program of **substance 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 treatments:

- 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.

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 Care
This is care given to a **terminally ill** person by or under arrangements with a Hospice Care Agency.

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**.

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.

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;
- 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; 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 **illness** 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 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.

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 **hospital**s (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.

Spinal Subluxation

This is any condition caused by or related to:

- Biomechanical; or
- Nerve conduction;

disorders of the spine.

Stay

This means a period during which an insured person is confined in a **hospital**. **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. 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**.
- 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 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**.
- Makes charges.
- 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 number 1-888-772-9682 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 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 FMLA leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If 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.