# Aetna Silver Medical Plan

This document is a Summary Plan Description (SPD), as defined by the Employee Retirement Income Security Act of 1974 (ERISA), of the Wayne Services Legacy, Inc. Health Benefits Plan (the "Plan"), consisting of the Aetna Silver Medical Plan that utilizes the Aetna Choice® POS II (Open Access) network.

This SPD is a summary of the main features of the Plan in effect as of July 1, 2019. If there is any discrepancy between the information contained in this SPD and the Plan documents, the Plan documents will always govern. If there are legal rules that require changes that are not yet written into the Plan document, the Plan document will be interpreted by the Plan Administrator as including those legal rules.

Please note that nothing in this SPD is meant to imply a contract or guarantee of employment. Participation in the Plan does not preclude the Company from terminating your employment at any time, whether or not for cause, with or without notice.

Please read this document carefully and share the information with your family. If you have any questions about this Plan, please contact Aetna at 1-800-589-4811.

This Summary Plan Description supersedes and replaces any previous SPDs you have received describing the Aetna Silver Medical Plan. The Company reserves the right to change, amend or terminate the Plan at anytime.

## Your Aetna Silver Medical Plan at a Glance

The following table highlights the benefits provided under the Aetna Silver Medical Plan. The Aetna Silver Medical Plan benefits may be subject to certain limits and restrictions. Be sure to review the rest of this Summary Plan Description (SPD) for a more complete description of Plan benefits. For information about participation requirements, see **Eligibility and Enrollment**; see **Administrative and Legal Information** for how to file a claim, continuation coverage, legal notices and where to obtain additional information.

| | Aetna Silver Medical Plan |
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| **Deductible (Per Plan Year)**<br><br>In Network – benefits are based on discounted rates<br><br>Out of Network – benefits are based on the recognized charge<br><br>**See Notes Below** | **In Network:**<br>$2,600 individual deductible<br><br>$5,200 two-person or family coverage<br><br>**Out of Network:**<br>$5,000 individual deductible<br><br>$10,000 two-person or family coverage |
| **Out-of-pocket Maximum (Per Plan Year – Includes Deductible)**<br><br>**See Notes Below** | **In Network:**<br>$6,350 individual maximum<br><br>$12,700 two-person or family coverage<br><br>**Out of Network:**<br>$12,700 individual maximum<br><br>$25,400 two-person or family coverage |
| **Notes** | Embedded Deductible AND Embedded OOP Max - each individual can satisfy their individual deductible for plan to pay at coinsurance level and OOP max at 100%. The balance of the family deductible and OOP Max can be met by the remaining family members |
| **Preventive Care** | **In Network:**<br>100% covered; no deductible<br><br>**Out of Network:**<br>50% covered; no deductible |
| **Office Visits** | **In Network:**<br>70% covered after deductible is met<br><br>**Out of Network:**<br>50% covered after deductible is met |
| **Hospital Care** | **In Network:**<br>70% covered after deductible is met<br><br>**Out of Network:**<br>50% covered after deductible is met |
| **Lifetime Maximum Benefit** | Limit does not apply |

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| **Prescription Drugs**<br>Retail pharmacy (up to a 30-day supply) | $10 co-pay after deductible is met<br><br>30% coinsurance after deductible for formulary brand name drugs (maximum payment – $200)<br><br>50% coinsurance after deductible for non-formulary brand name drugs (maximum payment – $400) |
| **Mail Order/Mail Service**<br>Prescription Drugs (up to a 90-day supply)<br><br>Must use CVS Caremark Home Delivery Pharmacy for mail order drugs or a CVS Caremark Pharmacy for the 90 day mail order fill at retail | $20 co-pay after deductible is met<br><br>30% coinsurance after deductible for formulary brand name drugs (maximum payment – $200)<br><br>50% coinsurance after deductible for non-formulary brand name drugs (maximum payment – $400) |
| **Specialty Drug Program**<br>(up to a 30-day supply) | Requires exclusive use of CVS Caremark Specialty Pharmacy for filling specialty drugs up to a 1-month supply. |

## The Aetna Silver Medical Plan

The Aetna Silver Medical Plan provides you with coverage for a broad range of medical and prescription drug expenses. When you or a covered dependent needs medical care, you can choose any provider you wish. However, Plan benefits are highest – and you pay less out of your own pocket – when you use a participating in-network doctor from the Aetna Choice® POS II (Open Access) network. Network providers have agreed to accept the negotiated charge. Aetna will reimburse you for a covered expense**,** incurred from a network provider**,** up to the negotiated charge and the maximum benefits under this Plan, less any cost sharing required by you such as deductibles and coinsurance. Your coinsurance is based on the negotiated charge. You will not have to pay any balance bills above the negotiated charge for that covered service or supply.

Out-of-network providers have not agreed to accept the negotiated charge**.** Aetna will reimburse you for a covered expense incurred from an out-of network provider, up to the recognized charge and the maximum benefits under this Plan, less any cost-sharing required by you such as deductibles and coinsurance**.** The recognized charge is the maximum amount Aetna will pay for a covered expense from an out-of-network provider. Your coinsurance is based on the recognized charge. If your out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred above the recognized charge. Except for emergency services, the Plan will only pay based on the recognized charge.

Plan benefits are generally less (*i.e.,* you pay more) when you use an out-of-network provider.

## Primary Care Physician (PCP)

You are encouraged to select a primary care physician (PCP) – but are not required to do so. When you select a PCP, he or she will provide your care, make referrals and coordinate any additional care you may need. You can choose a different PCP for yourself and each covered dependent. To find a PCP near you log onto Aetna Navigator at **www.aetna.com.**

## Deductible

The deductible is the amount you must pay each plan year before the Plan starts paying benefits for certain expenses, including most prescription drugs.

The Aetna Silver Medical Plan has an "embedded" deductible which means each individual can satisfy their individual deductible for the plan to pay at the coinsurance level. The balance of the family deductible can be met by the remaining family members.

In-network preventive care, such as routine physical exams, immunizations and certain screening tests are covered at 100%, with no deductible (subject to frequency limitations – see **Preventive Care**).

The deductible applies to all other in-and out-of-network expenses.

## Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you have to pay for eligible medical expenses in any plan year. Once your out-of-pocket expenses reach the maximum, the Plan pays 100% of all remaining in-network eligible covered expenses for that individual for the rest of that plan year, subject to the negotiated charge. The Plan pays 100% of all remaining out-of-network eligible covered expenses for that individual for the rest of that plan year, subject to the recognized charge.

The amount you pay toward your deductible along with coinsurance *are* included in your out-of-pocket maximum; however, the following expenses are *not* counted in determining whether you have reached the out-of-pocket maximum and are *not* reimbursed once the out-of-pocket maximum is met:

- Expenses above the negotiated and recognized charge
- Penalties for failure to obtain required precertification for Out of Network services
- Non-covered expenses (see excluded coverage section)

The Plan has "embedded" out-of-pocket maximums, meaning each individual can satisfy their individual out-of-pocket maximum for the plan to pay at 100%. The balance of the family out-of-pocket maximum can be met by the remaining family members.

## Pre-certification

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

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

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

**Important Note**

Please read the following sections in their entirety for important information on the precertification process, and any impact it may have on your coverage.

**The Precertification Process**

Prior to being hospitalized or receiving certain other medical services or supplies there are certain precertification procedures that must be followed.

You or a member of your family, a hospital staff member, or the attending physician, must notify Aetna to precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require precertification in accordance with the following timelines:

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

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| For non-emergency admissions: | You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted. |
| For an emergency outpatient medical condition: | You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible. |
| For an emergency admission: | You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted. |
| For an urgent admission: | You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury. |
| For outpatient non-emergency medical services requiring precertification: | You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled. |

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

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

If precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna's decision can be appealed. You or your provider may request

a review of the precertification decision pursuant to the Claims and Appeals section included with this Booklet.

**Services and Supplies Which Require Precertification**

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- Stays in a hospital;
- Stays in a skilled nursing facility;
- Stays in a rehabilitation facility;
- Stays in a hospice facility;
- Outpatient hospice care;
- Stays in a Residential Treatment Facility for treatment of mental disorders and substance abuse;
- Partial Hospitalization Programs for mental disorders and substance abuse;
- Home health care;
- Private duty nursing care;
- Infertility Treatments
- Intensive Outpatient Programs for mental disorders and substance abuse;
- Applied Behavioral Analysis;
- Neuropsychological testing;
- Outpatient detoxification;
- Psychiatric home care services;
- Psychological testing
- Transplants

**How Failure to Precertify Affects Your Benefits**

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

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

**How Your Benefits are Affected**

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

| If precertification is: | then the expenses are: |
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| ▪ requested and approved by Aetna. | ▪ covered. |
| ▪ requested and denied. | ▪ not covered, may be appealed. |
| ▪ not requested, but would have been covered if requested. | ▪ covered after a precertification benefit reduction is applied.* |
| ▪ not requested, would not have been covered if requested. | ▪ not covered, may be appealed. |

It is important to remember that any additional out-of-pocket expenses incurred because your precertification requirement was not met will not count toward your deductible or payment limit or maximum out-of-pocket limit.

## ID Cards

When you enroll in the Aetna Silver Medical Plan, you will receive two (2) ID Cards:

- An Aetna ID card to use for medical care

  *and*

- A prescription drug ID card from CVS Caremark.

If you do not receive your Aetna or CVS Caremark ID cards, or you need to fill a prescription or receive medical care before you receive your ID cards, you can print temporary ID cards from Aetna's website at **www.aetna.com** (you must register and log on to Aetna Navigator™ to access this feature) or **www.Caremark.com**. You or your provider can also contact Aetna Member Services to verify your coverage. To verify prescription drug coverage, contact CVS Caremark Member Services.

## Covered Expenses

The Aetna Silver Medical Plan provides benefits for the services and supplies specifically described in this Summary Plan Description, provided they are medically necessary. Out of network expenses are based on reasonable and customary limits.

## Preventive Care

The Plan covers doctors' charges for routine physical examinations and preventive screening tests for adults and children, including immunizations. A list of currently covered preventive services can be found online at **www.aetna.com.** Covered expenses and Plan benefits are shown on next page.

| For these preventive care services | The Plan pays |
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| **Routine Physical Exams** (including well child care) and preventive screening tests (X-rays and laboratory tests)<br>• Covered persons through age 21: Maximum age and visit limits subject to any age and visit limits provided for in the comprehesive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.<br>• Covered persons ages 22 and over, 1 visit per plan year | **In Network:**<br>100%; no deductible<br><br>**Out of Network:**<br>50%; no deductible |
| **Routine OB/GYN Exam** (including Pap test and related lab fees) – one each plan year | **In Network:**<br>100%; no deductible<br><br>**Out of Network:**<br>50%; no deductible |
| **Routine Mammogram** – one baseline mammogram between age 35 and age 40; one each plan year for women age 40 and older | **In Network:**<br>100%; no deductible<br><br>**Out of Network:**<br>50%; no deductible |
| **Non-Routine Mammogram** | **In Network:**<br>70%; after deductible is met<br><br>**Out of Network:**<br>50%; after deductible is met |
| **Routine Hearing Exam** – one every 24 months<br>Services must be provided by a legally qualified otolaryngologist, otologist or audiologist, or a certified audiologist who is directed in writing to perform the exam by a legally qualified specialist. Combined in and out of network limit. | **In Network:**<br>100%, no deductible<br><br>**Out of Network:**<br>50%; no deductible |
| **Immunizations and Flu Shots** | **In Network:**<br>100%, no deductible<br><br>**Out of Network:**<br>50%; no deductible |

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| **Obesity Preventive Counseling –** designed to aid in the managing and treatment of obesity. PCP's may perform assessments and provide results, handle outreach, and provide educational resources.<br>• Age 0-22 unlimited visits<br>• Age 22 and over, 26 visits per plan year of which up to 10 visits may be used for healthy diet counseling provided in connection with Hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. | **In Network:**<br>100%, no deductible<br><br>**Out of Network:**<br>50%; no deductible |
| **Tobacco Cessation Preventive Counseling –** Designed to aid in Smoking and Tobacco Use Cessation through counseling visits, treatments and Smoking Cessation classes in a PCP-type setting.<br>• Limited to 8 visits per plan year | **In Network**<br>100%, no deductible<br><br>**Out of Network**<br>50%; no deductible |
| **Other Preventive Care**<br>• Any other preventive care service required under federal law. For the complete list, please visit: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**.<br>• Women's preventive services as set forth in the Health Resources and Services Administrations Guidelines at **http://www.hrsa.gov/womensguidelines/** including but not limited to counseling and coverage for contraceptives. | **In Network**<br>100%; no deductible<br><br>**Out of Network**<br>50%; no deductible |

## Doctors' Services

The Plan covers doctors' charges for treatment of an illness, injury or pregnancy, as shown below.

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| **Doctors' Office Visits** | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network**:<br>50% after deductible is met |
| **Contraceptive Administration –** Medical plan covers office visit for injection of Depo-Provera and Lunell, Diaphragm fitting, and Cervical cap & IUD devices insertion/removal | **In Network:**<br>100% no deductible<br><br>**Out-of-Network**:<br>50% after deductible is met |
| **Contraceptive Counseling –** 1st two visits in-network per plan year and applicable physician/specialists cost shares applies thereafter. | **In Network:**<br>100% no deductible<br><br>**Out-of-Network:**<br>50% after deductible is met |
| **Maternity/Obstetric Care**<br>(physician's services for pre- and post-natal care for mother.<br><br>In-network deductible applies for post-natal care. | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| Additional Post-Natal Care Services: Coverage for:<br>• Lactation Consultants – In Network 100% no deductible for 1st 6 visits per plan year; Additional visits are subject to in-network deductible and coinsurance. Out-of-Network deductible and coinsurance applies<br>• Breast Pumps and Supplies – In Network 100% coinsurance for electric breast pump limited to 1 per 36 months; Out-of-Network deductible and coinsurance applies | **In Network:**<br>100% no deductible<br><br>**Out-of-Network**:<br>50% after deductible is met |

## Outpatient Care

The Plan covers the following services performed on an outpatient basis.

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| **Diagnostic Lab Tests/X-rays** – including pre-admission testing, CAT scans, MRIs and PET scans performed in an outpatient hospital or freestanding facility setting, including independent lab. | **In Network**:<br>70% after deductible is met<br><br>**Out-of-Network**:<br>50% after deductible is met |
| **Outpatient Rehabilitation** – short-term physical, occupational, speech and chiropractic* therapy, that within 60 days is expected to result in significant improvement of the function that has been lost or impaired due to injury, disease or birth defect | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network**:<br>50% after deductible is met<br><br>30 visit maximum for each type of therapy per plan year |
| * 30-day chiropractic maximum applies to spinal manipulation, and does not apply to expenses for treatment of scoliosis, fracture care or those related to surgery. | |

## Hospital Care

The Plan covers the following hospital services and supplies while you or a covered dependent is an inpatient or outpatient.

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| **Inpatient Hospital Care** – (pre-certification required for inpatient admissions) See IOQ note below | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network**: 50% after deductible is met |

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| semi-private room and board (charges for a private room may be covered at an in-network facility only, if requested by your provider and approved by Aetna; otherwise, the Plan covers charges up to the prevailing semi-private room rate in the area), and covered medical services, including:<br>• Anesthesia supplies and use of equipment<br>• Dressings and plaster casts<br>• Drugs and medicines for use in the hospital<br>• General nursing care<br>Intensive care, coronary care or other special care units and equipment<br>• Medical services and supplies customarily provided by the hospital, other than personal convenience items<br>• Oxygen and use of equipment for its administration<br>• Radiation therapy<br>• Use of blood transfusion equipment and administration of blood or blood derivates if administered by a hospital employee<br>• Use of operating, cystoscopic and recovery rooms<br>• X-rays and laboratory examinations | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:** 50% after deductible is met |
| **IOQ NOTE:** | IOQ are Institutes of Quality network of hospitals and other facilities which specialize in certain Bariatric, Cardiac and Orthopedic surgeries. They have been chosen based on their quality of results and level of care. You will receive higher level of benefits than other in-network providers and facilities. If an IOQ facility is used: |
| | IOQ Facility: 95% covered after deductible is met |

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| **Outpatient Hospital Care** – for the same services that would otherwise have been provided on an inpatient basis<br>Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:<br><br>• A physician or dentist for professional services;<br>• A surgery center; or<br>• The outpatient department of a hospital.<br><br>The surgery must meet the following requirements:<br><br>• The surgery can be performed adequately and safely only in a surgery center or hospital and<br>• The surgery is not normally performed in a physician's or dentist's office.<br><br>The following outpatient surgery expenses are covered:<br><br>• Services and supplies provided by the hospital, surgery center on the day of the procedure;<br>• The operating physician's services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and<br>• Services of another physician for related post-operative care and administration of anesthesia. This does not include a local anesthetic.<br>• The services of a physician or other health care provider who renders technical assistance to the operating physician.<br>• A stay in a hospital. Facility charges for office based surgery | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:** 50% after deductible is met<br>(**pre-certification** required) |

Coverage is also provided for:

- Maternity care – a minimum of 48 hours following vaginal delivery; 96 hours following delivery by cesarean section; earlier release possible after consultation between the attending physician and the mother
- Well baby nursery and physicians' charges during the initial confinement while the mother is confined in the same hospital – for up to the number of days medically necessary and appropriate

for the type of delivery (well baby nursery care will not be paid for any additional days the mother remains hospitalized due to an illness, injury, or complications following delivery).

## Alternatives to Inpatient Hospital Care

The Plan pays the following benefits for care received as an alternative to hospitalization.

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| **Home Health Care** – (pre-certification is required)<br>Is covered if provided by a certified home health care agency and recommended by a physician in lieu of hospitalization or confinement in a skilled nursing facility. Prior hospitalization is not required. Each visit by a nurse or therapist, and up to four hours of care by a home health aide, counts as one home health care visit.<br>60 visits per plan year maximum for in-network; and<br>30 visits per plan year maximum for out-of-network.<br>Covered services include:<br>• Medical supplies, drugs and medicines prescribed by a physician<br>• Necessary laboratory services<br>• Part-time or intermittent home health aide services<br>• Part-time or intermittent professional nursing care<br>• Physical, occupational and speech therapy | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |

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| Hospice Care – (pre-certification is required)<br>Covered for the medical care and treatment of a terminally ill patient, as recommended by a physician. Covered services include: | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network**:<br>50% after deductible is met |
| • Inpatient care for room and board, services and supplies for pain control and symptom management<br>• Outpatient care provided by a hospice care agency for:<br>  • Medical services and supplies<br>  • Part-time or intermittent nursing or home health aide care (up to 8 hours a day)<br>  • Medical social services under the direction of a physician<br>  • Psychological and dietary counseling<br>  • Physical and occupational therapy<br>  • Physician's services for consultation or case management<br>  • Drugs and medicines prescribed by a physician | |
| **Skilled Nursing Care** – (pre-certification is required)<br>If care is received by a registered nurse (RN) or licensed practical nurse (LPN) for:<br>• Visiting nursing care of up to 4 hours per visit<br>• Private duty nursing if the patient requires skilled nursing care and visiting nursing care is not adequate. 1 shift = up to 8 hours (unlimited shifts) | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |

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| Skilled Nursing Facility – (pre-certification required)<br>Coverage for inpatient care due to disease or injury if recommended by a physician in lieu of continued hospitalization.<br>Convalescent confinements must begin within 14 days following the end of a hospital confinement; covered services include:<br>• Room and board, including services such as general nursing care, up to the semi-private room rate<br>• Use of special treatment rooms<br>• X-ray and lab work<br>• Physical, occupational or speech therapy<br>• Oxygen and other gas therapy<br>• Medical supplies and other services | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |

## Emergency Care

The Plan covers the following services and supplies for emergency care.

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| Urgent Care Facility – to treat a condition that:<br>• Is severe enough to require prompt medical attention to avoid serious deterioration of the person's health<br>• Would subject the person to severe pain that could not be adequately managed without urgent care or treatment<br>• Does not require the level of care provided in a hospital emergency room<br>*and*<br>• Requires immediate outpatient medical care that cannot be postponed until the covered person's physician becomes reasonably available | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| **Hospital Emergency Room** | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:** 70% after deductible is met |

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| **Non-Emergency** | **In Network:**<br>50% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| **Ground, Air or Water Ambulance** – professional ambulance service to transport a covered person to the nearest hospital equipped to treat the condition | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>70% after deductible is met |
| **Non-Emergency Ground, Air or Water Ambulance** | **In Network:**<br>50% after deductible for non-emergency<br><br>**Out-of-Network:**<br>50% after deductible for non-emergency |

## Mental Health and Substance Abuse

The Plan covers:

- Alcoholism or drug abuse therapy prescribed and supervised by a physician, including:
  - Follow up therapy on at least a monthly basis

    *or*
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or drug abuse (e.g., Alcoholics Anonymous)
- Treatment by a mental health professional such as a psychiatrist, psychologist or psychiatric social worker.

Covered services are shown below.

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| **Inpatient Care** – semi-private room and board and necessary services and supplies in a hospital or residential treatment facility | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met (**pre-certification** required) |
| **Note:** | 1st $300 of hospital expenses are not covered when not pre-certified for Out of Network services |
| **Outpatient Care** | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |

## Other Covered Services

The Plan covers the following medical services and supplies.

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| **Autism Spectrum Disorder** - Outpatient Physical Therapy, Occupation al Therapy and Speech Therapy | **In Network**:<br>70% covered after deductible is met; limited to 30 visits per plan year<br><br>**Out of Network**:<br>50% covered after deductible is met; limited to 30 visits per plan year<br><br>**Combined in- and out-ofnetwork visit limit with non-Autism Spectrum Disorder diagnosis** |
| **Autism – Behavior Therapy** - Outpatient Behavior Therapy | **In Network:**<br>70% covered after deductible is met; unlimited visits per plan year<br><br>**Out of Network:**<br>50% covered after deductible is met; unlimited visits per plan year |
| **Autism - Applied Behavior Analysis** | **In Network:**<br>70% covered after deductible is met; unlimited visits per plan year<br><br>**Out of Network** 50% covered after deductible is met; unlimited visits per plan year |
| **Allergy Treatment** – includes testing and injections | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| **Bariatric Surgery –** surgical treatment of morbid obesity (check with Aetna for specific limitations and exclusions) | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |

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| **Dental Services** – for:<br>• Surgery needed to:<br>  • Treat a fracture, dislocation or wound<br>  • Remove cysts, tumors or other diseased tissue<br>  • Cut into gums or tissue of the mouth (when not in connection with the removal, replacement or repair of teeth)<br>  • Alter the jaw or bite when appliance therapy alone does not improve function<br>• Treatment of infection or disease that is not related to the teeth<br>• Dental work, surgery or orthodontic treatment needed to remove, repair, replace, restore or reposition sound natural teeth or mouth tissue damaged as a result of an injury (must be treated in the plan year of the incident or the following year); coverage provided for the first crown, denture, bridgework and/or appliance needed only | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| Durable Medical and Surgical Equipment (limited to one item of equipment for the same or similar purpose) – for:<br>• Rental expenses<br>• Initial purchase of equipment and accessories needed to operate it, provided the equipment is for long term use and cannot be rented or costs more to rent than to buy<br>• Repair or replacement of purchased equipment needed due to a change in the patient's physical condition or if it costs less than equipment rental<br>• Oxygen<br>The maximum benefit for foot orthotics is $250 per plan year for each covered person. | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| **Hearing Aids** (up to a maximum of $1,000 in a 36-month period) | 100% after deductible |

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| **Infertility Treatment** – for a woman:<br>• **Covered expenses** include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility<br>• **Covered expenses** will include expenses incurred by an eligible covered female for infertility if all of the following tests are met :<br>• A condition that is a demonstrated cause of infertility which has been recognized by a gynecologist, or an infertility specialist, and your physician who diagnosed you as infertile, and it has been documented in your medical records.<br>• The procedures are done while not confined in a hospital or any other facility as an inpatient.<br>• Your FSH levels are less than, 19 miU on day 3 of the menstrual cycle.<br>• The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy. | **In Network**:<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| **Outpatient ovulation induction and artificial insemination** – the following services will be covered on an outpatient basis provided a successful pregnancy cannot be attained through less costly treatment covered by the Plan, and the woman's FSH levels are less than or equal to 19 miU on day three (3) of the menstrual cycle: Up to 6 courses of treatment per lifetime | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |

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| • Artificial insemination, up to 6 courses of treatment per lifetime Artificial insemination, up to 6 courses of treatment per lifetime | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| **Advanced Reproductive Technology (ART), including:**<br>• In vitro fertilization (IVF)<br>• Zygote intra-fallopian transfer (ZIFT)<br>• Gamete intra-fallopian transfer (GIFT)<br>• Cryopreserved embryo transfers<br>• Intracytoplasmic sperm injection (ICSI) or ovum microsurgery<br>• Payment for charges associated with the care of an eligible covered person who is participating in a donor IVF program, including fertilization and culture<br>Charges associated with obtaining the spouse's or domestic partner's sperm for ART, when the spouse or domestic partner is also covered | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met<br><br>$15,000 medical lifetime maximum benefit for ART and $5,000 prescription lifetime maximum through the Prescription drug plan. Prescription drugs are not available through the medical plan. |
| **Oral Surgery –** includes surgical procedures to remove, repair, revise, reposition or replace the jaw or jaw joints – covers oral surgery that is medical in nature. | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| **Prosthetic Devices –** e.g. artificial limb; wigs; breast prosthesis | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| **RAPs** - Radiologists, Anesthesiologists and Pathologists Defines payment of non-participating practitioners who are pre-authorized to be paid at the in-network level; applies to both inpatient and outpatient | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| **Temporomandibular Joint Dysfunction (TMJ) –** covers medical-in-nature treatment only, including exams, TMJ surgery, x-rays, injections, anesthetics, physical therapy and oral surgery. | **In Network:**<br>70% after deductible is met<br><br>**Out-of-Network:**<br>50% after deductible is met |
| **Transplant Program -** Institutes of Excellence (IOE) for coordination of all solid organ and bone marrow | **In Network:** Covered same as any other expense for treatment in an approved IOE transplant facility or Aetna facility |

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| transplants (see more detail on page 33) | **Out-of-Network:** covered same as any other expense for treatment at a non-IOE transplant facility |
| **National Medical Excellence** (NME) for travel and lodging expenses (see more detail on page 32). | Travel and lodging allowances covered when pre-authorized by NME |
| Transgender Reassignment Benefit - Behavioral Services, Hormone Therapy* and Surgery | **In Network**:<br>70% covered after deductible is met<br><br>**Out of Network:**<br>50% covered after deductible is me |
| **NOTES** | *Hormone Therapy is through CVS Caremark – applicable coinsurance levels apply. See Prescription Drug information by Plan. |
| **Voluntary Sterilization** – but not the reversal of these procedures:<br>• Tubal ligation | **In Network:**<br>100% no deductible<br><br>**Out-of-Network:**<br>50% after deductible is met |

## Institutes of Excellence (IOE) Transplant Program ®

The IOE Program coordinates all solid organ and bone marrow transplants and other specialized care, including complex cardiac and neurosurgical procedures when the needed care is not available within the patient's local geographic area. The IOE program utilizes a national network of experienced IOE providers and facilities selected based on volume of cases and outcomes.

### *Important Reminders*

To ensure coverage, all transplant procedures need to be pre-certified by Aetna. Certain limitations and exclusion will apply. Please review your conditions thoroughly with Aetna.

## National Medical Excellence (NME) Program®

### *Transplant Services*

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart
- Lung
- Heart/Lung
- Simultaneous Pancreas Kidney (SPK);
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants

- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogeneic blood/bone marrow transplant (when not part of a tandem transplant)
- Allogeneic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant)
- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The network level of benefits is paid only for a treatment received at a facility designated by the plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.

The plan covers:

- Charges made by a physician or transplant team.
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; *or* upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The NME Program coordinates the following travel and lodging benefits when the patient uses an IOE facility for care and/or treatment that is more than 100 miles from his or her home*:

- Travel Expenses – for the patient and one companion for transportation between the patient's home and the IOE medical transplant facility to receive services in connection with a procedure or treatment.

Lodging Expenses – for the patient for lodging away from home while traveling between his or her home and the IOE medical transplant facility to receive services in connection with a procedure or treatment. Lodging expenses for one companion traveling with the patient are also covered, as well as expenses for a companion whose presence is needed to enable the patient to receive inpatient or outpatient care.

The Plan will pay lodging expenses for the patient and one companion up to a maximum of $50 per person per night (up to $100 total). The maximum combined benefit for travel and lodging expenses in connection with one procedure or type of treatment is $10,000.

Travel and lodging expenses in connection with one procedure or type of treatment will be paid from the day the individual becomes an NME patient, for up to one year or the date the patient no longer receives any services from the medical facility in connection with the procedure or treatment, whichever is earlier.

Benefits paid for travel and lodging expenses do not count against any person's maximum Plan benefit. Charges which are included as covered medical expenses under any other part of this Plan are not considered travel and lodging expenses.

* For the purpose of determining NME travel or lodging expenses, a hospital or other temporary residence from which an NME patient travels in order to begin a period of treatment, or to which he or she travels after discharge at the end of a period of treatment may be considered the NME patient's home.

## Prescription Drugs

Prescription drug coverage is provided by CVS Caremark. You must satisfy the plan year deductible before the plan pays for most prescription drugs.

The Prescription Drug benefit includes:

- Prescriptions for short-term use – You can fill prescriptions for short-term use (a 30-day supply or less) at any retail pharmacy.
- Maintenance Choice-You and your family can receive 90 days* supplies for long-term medication(s) through CVS Caremark Mail Service Pharmacy or at a CVS/pharmacy. Your copay will be the same.
- Prescriptions for maintenance drugs – CVS Caremark will cover the initial fill and one prescription refill for a maintenance drug obtained at a retail pharmacy.

  After the first refill (2nd fill), you ***must*** use the CVS Caremark home delivery service, or you will have to pay the full cost of the prescription. CVS Caremark will not provide benefits. You may also utilize the Maintenance Choice program and fill your maintenance drugs at a 90 day quantity at a CVS Caremark pharmacy.
- Prescriptions for specialty drugs – CVS Caremark will cover the initial fill ***only*** for specialty prescription drugs obtained at a retail pharmacy. After the initial fill, you ***must*** use the CVS Caremark Specialty Drug Program, or you will be responsible for the ***full cost*** of the prescription. CVS Caremark will not provide benefits.

  **Actual quantity may vary depending on your plan.*

When you use a participating CVS Caremark pharmacy to fill a short-term (up to a 30-day supply) prescription, you show your CVS Caremark ID card. If you use an out-of-network retail pharmacy, you must pay the full cost for your prescription and then submit a claim to CVS Caremark for processing.

To find a participating retail pharmacy, go to **www.caremark.com** or call **877-209-3213**.

### Prior Authorization and Quantity Standards

Your doctor or pharmacist must request prior authorization from CVS Caremark before prescribing or filling a prescription for certain types of drugs (growth hormones, weight loss medications, etc.). If you get a prescription for a medication on the prior authorization list and your doctor or pharmacist does not obtain prior authorization, *the prescription drug will not be covered*. In addition, there are certain medications that may have quantity limits to ensure that you are receiving the proper dose.

You can find a list of the drugs that require prior authorization and/or are subject to quantity standards by going to **www.caremark.com** or calling **877-209-3213**.

## Step Therapy

The Prescription Drug Step Therapy program is designed to help control prescription drug costs – for you and the Company – and, at the same time, help assure that you take the most effective medication to treat your condition. The program applies to individuals enrolled in an Aetna medical plan option who take medication for a chronic condition such as asthma, arthritis, high blood pressure, etc.

In general, first step medications are generic formulary drugs. If you try the first step and you and your doctor are not satisfied with the results, or your doctor decides that you need a different medication for medical reasons, then you would move to the next step. Medications that are prescribed after the first step are typically brand name drugs and have a higher copay.

For more information and the list of drugs that require step therapy, contact CVS Caremark Member Services. If your doctor prescribes one of these drugs, your pharmacist should contact your doctor to begin the step therapy process.

## CVS Caremark Specialty Pharmacy

CVS Caremark Specialty Pharmacy, a Designated Dispensing Entity, is the preferred specialty pharmacy provider for Wayne Services Legacy, Inc. A list of medications that must be dispensed by CVS Caremark Specialty Pharmacy can be found at **www.caremark.com**.

The list is subject to change. Please call **1-877-209-3213** for the most current list of covered specialty medications dispensed by the CVS Caremark Specialty Pharmacy. Plan members will be referred to the manufacturer's designated specialty pharmacy provider for limited distribution drugs (i.e., specialty medications listed that are not currently available through CVS Caremark Specialty Pharmacy).

In general, the drugs on this list will not be covered by any pharmacy except for CVS Caremark Specialty Pharmacy, regardless of their medical necessity, their approval, or if the member has a prescription by a physician or other provider. In limited circumstances, however, coverage may be allowed through an alternate provider. Those circumstances include:

1. Specialty medications billed by a facility as part of an inpatient hospital stay.*
2. Specialty medications billed as part of an emergency room visit.*
3. Situations where Medicare is the primary carrier.*
4. Limited distribution specialty medications where CVS Caremark does not have access to the drug.*
5. Circumstances where homecare is not clinically appropriate (either due to the member's clinical history or due to characteristics of the drug which require special handling) and an alternative infusion site (that is qualified to administer the drug) is not available for coordination of services within a reasonable proximity (30 miles or less).**
6. The treating physician has provided written documentation outlining the clinical rationale for the requirement that the member be treated at the designated facility and confirming that the designated facility is unable to accept drug dispensed by CVS Caremark. The written documentation will be reviewed and approved by appropriate CVS Caremark clinical personnel before allowing coverage for the requesting provider under the medical benefit.**

*Prior approval by CVS Caremark is not required.
**Situation will be evaluated by CVS Caremark clinical staff.

Select specialty medications will be covered only under the pharmacy benefit through CVS Caremark Specialty Pharmacy. As part of this policy, these specialty medications will be excluded from coverage under the medical benefit.

Prior authorization and specialty preferred drug plan design management may be required regardless of the benefit under which the drug is covered or the identity of the provider who is administering the drug.

A list of specialty medications that are only covered under the pharmacy benefit and must be dispensed by CVS Caremark Specialty Pharmacy can be found on **www.caremark.com**

The list is subject to change. Please call **1-877-209-3213** for the most current list of specialty medications covered under the pharmacy benefit through the CVS Caremark Specialty Pharmacy.

In addition, for designated specialty medications where coverage is still allowed under the medical benefit, the drug, drug dosage(s) and site(s) of care for infusion therapy may require prior authorization for medical necessity, appropriateness of therapy and patient safety.

## Infusion Nursing and Site of Care Management for Specialty Medications

Infusion nursing services for select specialty medications that are administered in the home and/or in an ambulatory infusion center are covered through the pharmacy benefit and are coordinated through and dispensed by the CVS Caremark Specialty Pharmacy. For non-oncology infused specialty medications that require administration by a medical professional, a Care Team nurse will work with you and your provider to assess your clinical history and determine clinically appropriate options (location for your infusion) for clinician-infused specialty medications. Options may include homecare, an ambulatory infusion center, physician office, etc. Care Team nurses will contact all impacted members to provide assistance and guidance.

## Benefit Limitations

The Aetna Silver Medical Plan does not include a lifetime maximum dollar cap.

Some covered services are subject to separate limits and/or annual maximum benefits. These limits and maximums apply to each covered individual, and to in- and out-of-network care combined (unless specified otherwise). The following limits apply, subject to any preventive care requirements under the ACA:

- *Chiropractic care* – 30 visits per plan year for spinal manipulation (maximum does not apply to expenses for treatment of scoliosis, fracture care or those related to surgery)
- *Colorectal cancer screening* – one per plan year for individuals age 50 and older
- *Foot orthotics* – up to a maximum of $250 per plan year
- *Gynecological exams* (routine) – once in a plan year in conjunction with an office visit
- *Hearing aids* – up to a maximum of $1,000 every 36 months
- *Hearing exam* – one every 24 months
- Home health care – *In-network: 60 visits per plan year maximum (Home Health Aid is 4 hours = 1 visit;* Nurse *or Therapist – 1 visit);* Out-of-network: *30 visits per plan year maximum*
- *Infertility services* –
  - Up to six courses/cycles of treatment per lifetime for each of the following two services: artificial insemination and ovulation induction
  - Up to a medical lifetime maximum of $10,000 for Advanced Reproductive Technology (ART), including in vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intra-fallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery, and care associated with a donor IVF program (including

fertilization and culture) and up to a prescription drug lifetime maximum of $5,000 through CVS Caremark.

- *Mammography* (routine) – one baseline between age 35 and age 40; one each plan year at age 40 and older
- *Occupational therapy* (outpatient) – 30 visits per plan year
- *PAP tests* – once in a plan year in conjunction with an annual physical or gynecological exam
- *Physical exams* (routine) – one every 12 months for individuals ages 7 and older (includes immunizations and flu shots)
- *Physical therapy* (outpatient) – 30 visits per plan year
- *Prostate screening and digital rectal exam* – one per plan year for men age 40 and older
- *Speech therapy* (outpatient) – 30 visits per plan year
- *Well child care* (routine) – immunizations and child to age 18: 7 exams in the 1st 12 months; 3 exams in the 13th-24th months; 3 exams in the 25th-36th months; 1 exam per plan year thereafter.

## Excluded Coverage

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary. Charges made for the following are not covered except to the extent listed under Covered Expenses.

Acupuncture, acupressure and acupuncture therapy, except as provided in the Covered Expenses section.

Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this SPD.

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

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

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

Behavioral Health Services:

- Alcoholism or substance abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for detoxification or treatment of alcoholism or substance abuse is specifically provided in the Covered Expenses Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.

- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the Covered Expenses section of this SPD.

Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

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

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

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.

Contraception, except as specifically described in the Covered Expenses Section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when medically necessary;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically provided in the Covered Expenses section.

Court ordered services, including those required as a condition of parole or release.

Custodial Care

Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Outpatient prescription drugs;
- Self-injectable prescription drugs and medications;
- Any prescription drugs, injectables, or medications or supplies provided by the customer or through a third party vendor contract with the customer; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations:

- Any health examinations required:
  - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - by any law of a government;
  - for securing insurance, school admissions or professional or other licenses;

- to travel;
- to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

Any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the Covered Expenses section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion does not apply to specialized medical foods delivered enterally (only when delivered via a tube directly into the stomach or intestines) or parenterally.

Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury.

Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a stay in a hospital or other facility;
- Replacement parts or repairs for a hearing aid; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except as otherwise provided under the Covered Expenses section.

Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds. and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;

- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Infertility: except as specifically described in the Covered Expenses Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a physician's practice;
- Charges to have preferred access to a physician's services such as boutique or concierge physician practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;

- Any care a public hospital or other facility is required to provide; or
- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your stay in a hospital, and outpatient private duty nursing services, except as specifically described in the *Private Duty Nursing* provision in the Covered Expenses Section.

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

Services of a resident physician or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet.

Services that are not covered under this SPD.

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

Speech therapy for treatment of delays in speech development, except as specifically provided in the Covered Expenses *Section*. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the Covered Expenses section.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Tobacco Use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically provided in the Covered Expenses section.

Transplant-The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;

- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified by Aetna.

Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in the *Covered Expenses* section.

Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Aetna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Vision-related services and supplies, except as described in the *What the Plan Covers* section. The plan does not cover:

- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your stay in a hospital or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions; except as specifically provided in the *Covered Expenses* section, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity;
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Wilderness treatment programs (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Work related: Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

## Prescription Drug Exclusions

The prescription drug program does not cover expenses for:

- Appetite suppressants (unless prior authorization is received)
- Biological sera and blood products
- Charges for the administration or injection of any drug
- Depigmentation products
- Devices of any type unless specifically included as a prescription drug
- Diagnostic agents
- Drugs:
  - That are purchased over-the-counter
  - Purchased from a non-participating home delivery service
  - That do not, by law, require a prescription
  - To promote hair growth
- Immunization agents
- Infertility drugs above the $5,000 lifetime maximum
- Injectable cosmetics and allergy sera or extracts
- Injectable and topical medications used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy
- Intravenously administered medications
- IUDs
- Legend vitamins and homeopathic medications (those that require a prescription)
- Less than a 30-day supply of any drug purchased through the home delivery service
- Medications provided during a hospital stay or by an outpatient facility, except as noted in the Specialty Drug section that would be covered as medical expenses under the Aetna Silver Medical Plan
- More than a 30-day supply per prescription (unless purchased through the home delivery service)
- Nutritional supplements
- Photo age skin products
- Refills of a drug purchased more than one year (or the duration permitted where the drug is dispensed) after the latest prescription
- Refills that exceed the number of refills prescribed (CVS Caremark may request a new prescription)
- Smoking cessation aids or non-prescription smoking cessation drugs, except as required under the ACA as preventive care
- Unit dose medications.

## Plans Other than Medicare

The Aetna Silver Medical Plan contains a maintenance of benefits (non-duplication of benefits) feature. This feature applies when you or an eligible covered dependent are covered by more than one group plan providing health benefits (or by no-fault auto insurance required by law that is not a group plan). It limits payments from all sources combined to no more than what the Aetna Silver Medical Plan would pay if there had been no other coverage.

## Effect of Benefits under Other Plans

This plan always pays secondary to:

- Any medical payment, PIP or No-Fault coverage under any automobile or premises coverage available to you.
- Any plan or program which is required by law.
- All Covered persons should review their automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

When health benefits are payable under two or more plans, the plan with primary responsibility always pays first. The order in which the plans will pay benefits is determined using the first rule that applies from the following list:

- If a plan does not have a coordination of benefits provision, that plan is considered primary.
- The plan that covers the person as an employee or group member is primary, and the plan that covers the person as a dependent is secondary, except under certain circumstances when the person is also a Medicare beneficiary (contact Aetna Member Services for more information about coordination for Medicare beneficiaries).
- The plan that covers the parent whose birthday comes first in the calendar year (month and day) is primary for an eligible dependent child, unless:
  - Both parents have the same birthday, and then the plan that has covered one parent the longest is primary
  - The other plan has a gender-based coordination of benefits rule, then the other plan determines the order of benefits
  - The parents are divorced or separated; in that case if:
    - There is a court decree that specifies one parent is financially responsible for the medical, dental or other health care expenses of the child, then that parent's plan is primary
    - There is no court decree that specifies financial responsibility then the order of payment is the plan of the: (1) custodial parent; (2) spouse of the custodial parent; and (3) non-custodial parent
- The plan that has covered the person the longest will be primary, except:
  - A plan that covers the person as an employee who is not laid-off or retired (or the employee's dependent) determines benefits before a plan that covers the person as a laid-off or retired employee (or that person's dependent)
  - A plan that covers the person through continuation rights under federal or state law determines benefits after a plan that does not provide coverage through continuation rights.

Aetna may release or obtain data to administer the maintenance of benefits provision, and can also make or recover payments.

When benefits under the Aetna Silver Medical Plan are reduced as a result of the maintenance of benefits provision, the reduced amount will count toward any applicable Plan limits (for example, Chiropractic care visit maximum).

## Effect of a Health Maintenance Organization (HMO) on Coverage

The Plan coordinates benefits with an HMO if:

- You are covered as a dependent under your spouse's (or domestic partner's) HMO and are also enrolled in the Aetna Silver Medical Plan

  *or*

- Your spouse (or domestic partner) is covered by an HMO and is also enrolled as your dependent in the Aetna Silver Medical Plan.

In these instances, you may file a claim under the Aetna Silver Medical Plan for expenses not covered by the HMO. If the claim is for a covered expense under the Aetna Silver Medical Plan, the Aetna Silver Medical Plan will pay its regular benefit.

## Effect of Medicare on Coverage

At age 65, or earlier if disabled, you may become eligible for Medicare, a U.S. federal government health insurance program. You may enroll for Medicare, and can do so whether or not you continue to work once you become eligible.

Once you become eligible for Medicare, benefits under the Aetna Silver Medical Plan may be reduced so that total benefits paid under the Aetna Silver Medical Plan and Medicare do not exceed 100% of the total covered expense. Medicare benefits will be taken into account if you enroll for Medicare. Rules for coordinating any other benefit plans with the Aetna Silver Medical Plan will apply after coordination with Medicare benefits.

### If You Continue to Work after Age 65

If you choose to be covered by the Aetna Silver Medical Plan and have enrolled in Medicare, your Aetna Silver Medical Plan coverage will be primary to Medicare. Medicare will become your secondary plan and provide coverage for eligible expenses that the Aetna Silver Medical Plan does not cover in full. If you are working for Wayne Services Legacy, Inc. when your spouse or domestic partner becomes Medicare eligible, he or she will have the same coverage as you have elected for yourself, if you elect family coverage.

If you make no election with respect to Medicare you will continue to be covered by the Aetna Silver Medical Plan until the date you are no longer eligible or waive coverage, whichever is earlier.

If you elect to have Medicare as your primary coverage, you will not be eligible to receive benefits from the Aetna Silver Medical Plan because federal law prohibits offering supplemental benefits for expenses covered under Medicare to active team members or their dependents.

Before you reach age 65, you should contact your local Social Security office to notify them that you will remain actively employed and have elected to continue coverage under your employer's medical plan. Otherwise, you will be charged a higher premium for Medicare Part B when these benefits subsequently begin.

***If you are age 65 and eligible for Medicare because of a disability,*** the Aetna Silver Medical Plan will be the primary payer if you are entitled to Medicare Part A and are covered as a result of your or a

dependent's current employment status. However, if you are disabled as a result of End Stage Renal Disease ("ESRD") your Aetna Silver Medical Plan coverage will be primary for a 30-month period beginning with either: (1) the first of the month in which you become entitled to Medicare Part A due to ESRD; or (2) the first of the month you would have been entitled had you applied, whichever occurs first.

Since Medicare rules are complicated, you are encouraged to contact Aetna Member Services.

## Effect of Prior Coverage

If coverage under the Aetna Silver Medical Plan replaces any prior Company-sponsored coverage, you will no longer be entitled to benefits under the prior plan. Benefits provided under the prior plan may reduce benefits payable under the Aetna Silver Medical Plan.

# Claiming Benefits

## Medical Claims

Aetna administers all medical claims. Medical services you receive from an in-network provider generally require no claim forms. As a courtesy, most in-network providers will handle all of the necessary paperwork – though some may require you to file a claim form. Generally, you do not owe payment at the time of service however; some providers may require a deposit for more expensive courses of treatment. Have the provider check with Aetna before making any upfront payment as you may have met your deductible and out-of-pocket maximums. If you receive care from an out-of-network provider you may need to file a claim form for reimbursement if you pay the out-of-network provider prior to the claim being submitted. Submit the completed form to Aetna at the address shown on the form. Be sure to include all of the necessary documentation.

## Prescription Drug Claims

CVS Caremark, Inc. (CVS Caremark) administers all prescription drug claims. There are no claims to file when you purchase prescriptions from an in-network retail pharmacy, the CVS Caremark home delivery program, or the CVS Caremark Specialty Drug Program. If you use an out-of-network retail pharmacy, you must pay the full cost for the prescription and then file a claim form for reimbursement. Submit the completed form to CVS Caremark at the address shown on the form. Be sure to include all of the necessary documentation.

Prescription drug benefits, with the exception of certain preventive drugs, will not be paid by the plan until you satisfy the applicable medical deductible.

For information regarding claim filing deadlines, determinations and appeals, see **Administrative and Legal Information**.

## Payment of Benefits

Benefits are paid as soon as administratively possible once the Claims Administrator receives the necessary documentation to support the claim. Benefits are paid directly to the provider, however if you receive out-of-network care or services and have paid the provider, you may request that benefits be paid to you.

The Plan can pay up to $1,000 of benefits to a relative whom it believes to be fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate. **Note:** This provision applies to medical benefits only; it does not apply to prescription drug coverage through CVS Caremark.

## Records of Expenses

It is important to keep a complete record of expenses for each covered person, as documentation will be required when a claim is made. Records should include:

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

## Recovery of Overpayment

If Aetna makes a benefit payment that is more than you are entitled to under the provisions of the Plan – including any payments made under the maintenance of benefits provision – the Claims Administrators reserve the right to have the extra amount returned or reduce any future benefit payments to recover the amount of the overpayment.

## Subrogation and Right of Recovery Provision

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

## Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

## Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

## Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogration and reimbursement interest are fully satisfied.

## Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

## Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

## First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan participant is fully compensated by his/her recovery from all sources.

## Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

## Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but

not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in person injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

### Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

### Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

## Qualified Medical Child Support Order (QMCSO)

Federal law requires group health plans to honor qualified medical child support orders (QMCSOs) which apply to the Aetna Silver Medical Plan.

In general, a QMCSO is a state order requiring a parent to provide medical support to a child in case of separation or divorce and under certain statutory conditions. Upon receipt of a medical child support order (MCSO), you and the affected child will receive notice that the order is being reviewed by the Plan to determine if it is qualified and the procedures being used to do so. If the Plan determines that the order is qualified, it will pay benefits directly to the child, the child's custodial parent or legal guardian. If the order is determined to be qualified, both you and the child will be enrolled in the Plan automatically.

### In the Event of Your Death

If you die while you are an active team member covered under the Aetna Silver Medical Plan, your covered dependents will receive 60 days of COBRA coverage at no cost, provided you elect COBRA coverage within the required deadline. At the end of the 60 days, continued coverage is available for up to an additional 34 months at full COBRA (See Continuation of Coverage on next page) rates.

## Termination of Coverage

Aetna Silver Medical Plan coverage stops when:

- You stop making the required contributions
- At 11:59 p.m. on the day your employment ends or you are transferred to an ineligible class of employment
- The Plan ends
- You die
- The Plan is amended to exclude the class of employees that includes you
- You are no longer eligible.

Your dependent's active coverage ends when yours does or when he or she:

- Loses his or her eligibility due to age − except for a disabled child for whom coverage can continue (see **Eligibility and Enrollment** for more information)
- Becomes covered as a Wayne Services Legacy, Inc.team member
- Otherwise ceases to meet the Plan's eligibility requirements (*e.g.,* divorce).

## Continuation of Coverage (COBRA)

Federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA) requires that the Aetna Silver Medical Plan offer team members and their families the opportunity for a temporary extension of coverage (called "continuation coverage") when coverage would otherwise end due to certain events called "qualifying events". The following is a summary of your rights and obligations under the continuation coverage provisions of the law.

If coverage under the Aetna Silver Medical Plan ends as a result of a "qualifying event," you and/or your eligible family members can elect to continue coverage, as shown below.

| Eligible Family Member | Qualifying Event | You can choose continuation coverage for up to |
|---|---|---|
| **Team member** | • Reduction in your hours of employment or transfer to an ineligible class of employment<br>• Termination of your employment (for reasons other than gross misconduct on your part) | 18 months |
| | • The team member or a covered dependent is disabled at termination of employment or reduction in hours or within the first 60 days of continuation coverage | 29 months |
| **Spouse or domestic partner of a covered team member** | • Termination of the team member's employment (for reasons other than gross misconduct)<br>• Reduction in the team member's hours of employment or transfer to an ineligible class of employment | 18 months |
| | • The team member or a covered dependent is disabled at termination of employment or reduction in hours or within the first 60 days of continuation coverage | 29 months |
| | • Death of the team member<br>• Divorce or legal separation from the team member, or end of the team member's domestic partnership | 36 months |
| **Dependent child of a covered team member, the team member's spouse or domestic partner*** | • Termination of parent's employment (for reasons other than gross misconduct)<br>• Reduction in parent's hours of employment or transfer to an ineligible class of employment | 18 months |
| * A child born to or placed with you for adoption during a period of continuation | • The team member or a covered dependent is disabled at termination of employment or reduction in hours or within the first 60 days of continuation coverage | 29 months |

| Eligible Family Member | Qualifying Event | You can choose continuation coverage for up to |
|---|---|---|
| coverage is also eligible for continuation coverage. | • Death of the team member<br>• Parents' divorce, legal separation, or domestic partnership ends<br>• Child is no longer an eligible dependent | 36 months |

If your qualifying event is termination of employment or reduction in hours of employment and you became entitled to Medicare less than 18 months before the date coverage ended, the maximum COBRA period for your enrolled dependents lasts until 36 months after the date you became entitled to Medicare.

## Your Responsibilities under the Law

Under the law, you or your dependent has the responsibility to notify Wage Works, the COBRA Administrator, of your divorce, legal separation, or a child losing dependent status under the Aetna Silver Medical Plan. You must notify the COBRA Administrator within 60 days after the later of:

The date of the qualifying event

*Or*

The date you would lose coverage due to a qualifying event.

If notice is not made within this time period, you will lose your right to elect continuation coverage.

If you discontinue your spouse's coverage in anticipation of a divorce or legal separation, COBRA continuation coverage will be available effective from the date of the divorce or legal separation (but not before that date). If you need help acting on behalf of an incompetent beneficiary, contact the COBRA Administrator for assistance.

Once the COBRA Administrator is notified of a qualifying event, the dependent(s) losing coverage will be notified of the right to choose COBRA continuation coverage.

If you or your dependent continues coverage under COBRA, and that person's marital status or mailing address changes, he or she must notify the COBRA Administrator on a timely basis.

## Employer's Responsibilities under the Law

Wayne Services Legacy, Inc. has the responsibility to notify Aetna in case of your death, termination of employment, reduction in hours or transfer to an ineligible class of employment, within 30 days of being notified of the event. Once Aetna is notified, the COBRA Administrator will notify you of your right to choose continuation coverage within 14 days of notification.

## Choosing Continuation Coverage

If you choose continuation coverage, your coverage under the Aetna Silver Medical Plan will be the same as it would have been had you not lost coverage. Your spouse or dependent children may elect to continue coverage, even if you do not make the election.

You have 45 days from the date of the initial election to make your first premium payment and any other premium payments that are due for periods of coverage that end before 45 days from the date of the

election. Subsequent premiums are due on the premium due date, and must be paid in full within the 30-day grace period. The monthly premium is 102% of the full cost of coverage.

**Note**: Some states offer financial aid to help certain individuals pay for COBRA coverage. Contact your appropriate state agency regarding availability and eligibility requirements.

## Duration of Coverage

The duration of COBRA coverage was explained earlier. However, your Aetna Silver Medical Plan COBRA coverage may stop before then for any of the following reasons:

- Wayne Services Legacy, Inc. no longer provides medical and/or prescription coverage to any of its team members
- you do not pay the premium for continuation coverage in a timely manner
- you or your dependent becomes covered under another group medical and/or prescription plan (whether or not as an employee), unless that plan contains a provision that restricts the payment of benefits for a pre-existing condition that is not satisfied by the individual under the provisions of the Health Insurance Portability and Accountability Act of 1996.

Once continuation coverage stops, it cannot be reinstated. If you have any questions about the law, please contact the COBRA Administrator.

## Continuation Coverage under the Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

This federal law generally allows individuals called for military service to continue coverage for themselves and their dependents under the Plan. If you are on an approved military leave, you and your family can continue coverage for the duration of your leave – up to a maximum of five years – at the applicable team member contribution rate. If military service is longer than five years, you and your family may continue medical and dental coverage through COBRA.

If you don't continue your benefits during the leave or if you fail to make any of the required payments, you lose coverage as of the date you fail to make payment. You will receive information concerning your rights under COBRA at that time. When you return from leave, the benefits you had before your leave, or the benefits that are available upon your return from leave, will be reinstated as required by law unless you have made changes during Annual Enrollment or as a result of a qualified status change. If you do not return to employment, Wayne Services Legacy, Inc. may collect any unpaid contributions, as permitted by law.

State law may provide additional rights.

For more information, including rates and time frames, contact Wage Works at 800-526-2720.

## Glossary of Key Terms

To help you understand how the Aetna Silver Medical Plan works, you should familiarize yourself with the following key terms.

***Aetna Member Services*** – Call **1-800-589-4811** or log on to **www.aetna.com**.

***Claims Administrators*** – For:

- Medical coverage – Aetna Inc.
- Prescription drug coverage – CVS Caremark.

***COBRA Administrator*** – Wage Works

***Coinsurance*** – The percentage of the cost you pay for covered expenses, once the appropriate deductibles have been satisfied.

***Companion*** – A person whose presence as a companion or caregiver is necessary to enable a National Medical Excellence (**NME**) Program patient to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis, or travel to and from the facility where treatment is given.

***Convalescent facility (Skilled nursing facility)*** – An institution, licensed and operated according to law, that is primarily engaged in providing inpatient care for convalescence from an illness or injury. It must provide 24-hour a day professional nursing care by a registered nurse (RN), or by a licensed practical nurse (LPN) directed by a full-time RN; as well as physical restoration services to help patients achieve self-care in daily living activities. The facility must be supervised full-time by a physician or RN, keep a complete medical record on each patient and have a utilization review plan in place. It is not to be used mainly for rest, the aged, drug addicts or alcoholics, mental illness, or custodial or educational care.

***Copay*** – A flat dollar amount you pay for certain covered medical services, such as generic prescription drugs.

***CVS Caremark Member Services*** – For information about your prescription drug benefits, or to locate a participating pharmacy, log on to **www.caremark.com** or call **1-877-209-3213**.

***Custodial care*** – Room, board, and other institutional services and supplies provided mainly to help a person with activities of daily life, such as bathing, feeding, and administration of oral medicines or other services which can be provided by someone other than a trained health care provider. A person does not have to be disabled to receive custodial care.

***Deductible –*** The amount you must pay each plan year before the Aetna Silver Medical Plan pays any benefits.

***Dentist*** – An individual holding a degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who practices within the scope of his or her license under the laws of the state or jurisdiction in which services are provided. In addition, a physician who performs dental work within the scope of his or her license may be considered a dentist.

**Designated Dispensing Entity:** A Designated Dispensing Entity is a pharmacy or other provider that has entered into an agreement with the Plan or with an organization contracting on behalf of the Plan, to provide specialty medications for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity. If you are directed to a Designated Dispensing Entity and you choose not to obtain your specialty medication from a Designated Dispensing Entity, you will be subject to the non-network benefit terms for that specialty medication.

***Doctor (Physician)*** – An individual holding a degree of Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatric Medicine (DPM) or Doctor of Chiropractic (DC), who practices within the scope of his or her license under the laws of the state or jurisdiction in which the services are provided.

***Durable medical and surgical equipment*** – Equipment (plus the accessories to operate it) made to withstand prolonged use and primarily to treat a disease or injury. The equipment must be suited for home use, and may not be intended for:

- Altering air quality or temperature
- Exercise or training
- Normal use by individuals who are not ill or injured.

Not included is equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over-bed tables, elevators, communication aids, vision aids and telephone alert systems.

***Effective treatment of a mental disorder*** – A program prescribed and supervised by a physician to treat a disorder that can be favorably changed.

***Emergency*** – A recent and severe medical condition – including severe pain – which would lead the average person to believe that failure to get immediate medical care could result in serious risk to his or her health or bodily function (or in the case of a pregnant woman, serious risk to the health of the fetus).

***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 U. S. Food and Drug Administration (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, procedure 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.

***Formulary brand name drug*** – A prescription drug protected by trademark registration and included on the CVS Caremark formulary listing. These drugs may or may not have a generic equivalent.

***Generic drug*** – A prescription drug which is not protected by trademark registration, and is produced and sold under the name of the chemical formulation. Generic drugs are certified by the FDA to be as effective as their brand name equivalents, and meet the same standards.

***Health Savings Account (HSA) –*** An account created for individuals who are covered under high-deductible health plans (HDHPs) to save for medical expenses that HDHPs do not cover. Contributions are made into the account by the individual or the individual's employer and are limited to a maximum

amount each year. The contributions are invested over time and can be used to pay for qualified medical expenses, which include most medical care such as dental, vision and over-the-counter drugs.

***Home health care agency*** – A public or private agency or organization, licensed and operated according to law, which mainly provides skilled nursing and other therapeutic services in the patient's home. The agency must be associated with a professional group that has at least one physician and one registered nurse (RN), and must be supervised by at least one physician or registered nurse.

***Home health care plan*** – A plan that provides for care and treatment of a disease or injury, which must be prescribed in writing by the attending physician and an alternative to confinement in a hospital or convalescent facility.

***Hospice care*** – Care given to a terminally ill patient with a life expectancy of no more than 24 months, arranged through a hospice care agency.

***Hospice care agency*** – An agency or organization, licensed and operated according to law, which provides hospice care 24-hours a day including skilled nursing services, medical social services and psychological and dietary counseling. In addition, the agency will provide or arrange for other services, such as physician's services, physical and occupational therapy, part-time home health aide services and inpatient care when needed for pain control and acute and chronic symptom management. The agency must be staffed by at least one physician, one RN, one licensed or certified social worker and a full-time administrator. It is the responsibility of the agency to:

- Develop a hospice care program for each patient
- Provide an ongoing quality assurance program, including reviews by physicians other than those who own or direct the agency
- Permit all area medical personnel to utilize its services for their patients

  *and*
- Keep a medical record on each patient.

***Hospice care program*** – A written plan of hospice care, established and reviewed periodically by the patient's attending physician and the appropriate personnel of a hospice care agency. The program must include an assessment of the patient's medical and social needs, in addition to a description of the care to be given to meet those needs. A hospice care program is designed to provide palliative and supportive care to terminally ill patients, as well as supportive care to their families.

***Hospital*** – A public or private facility, licensed and operated according to law, which provides inpatient surgical and medical diagnosis, treatment and care to individuals who are injured or ill. The facility must be under the supervision of physicians, with registered nurses (RNs) on duty at all times. A hospital does *not* include an institution, or part of one, which is mainly a place for rest, the aged, drug addicts, alcoholics or for convalescent care.

***In-network provider (Participating provider, Preferred provider)*** – A state licensed health care provider who has a written agreement with Aetna to perform services and receive payment at a discounted rate.

***Maintenance drug*** – A prescription drug used on a long-term basis to treat a chronic condition.

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

The service or supply is considered appropriate if it is as likely to produce a significant positive outcome – or result in information that could affect the course of treatment – as any alternative service or supply, given the disease or injury involved and the person's overall health condition. The service or supply must also be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply.

Aetna will consider the following when determining if a service or supply is appropriate:

- Information provided about the individual'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.

Services or supplies will *not* be considered medically necessary if they:

- Do not require the technical skills of a medical, mental health or dental professional
- Are provided mainly for the personal comfort or convenience of the patient, a person who cares for him or her, a family member, a healthcare provider or healthcare facility
- Are provided to an individual as an inpatient when the disease or injury could safely and adequately be diagnosed or treated while not confined

  *or*

- Are provided in a particular setting when they could safely and adequately be furnished in a physician's office or other less costly setting.

***Mental disorder*** – A disease commonly understood to be a mental disorder, for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, psychologist or psychiatric social worker. Mental disorders include, but are not limited to:

- Alcoholism and drug abuse
- Schizophrenia
- Bipolar disorder
- Pervasive mental developmental disorder (autism)
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder.

***Morbid obesity*** – A condition in which an individual has a Body Mass Index (BMI) that is:

- Greater than 40

  *or*

- Equal to or greater than 35 and the excess weight causes a medical condition such as hypertension, sleep apnea, diabetes or a cardiopulmonary condition.

***Negotiated charge*** – The maximum charge a network provider has agreed to make as to any service and supply for the purpose of the benefits under this Plan.

***NME patient*** – A person who requires any NME procedure or treatment covered under the Plan, contacts Aetna and is approved as an NME patient, and agrees to have the procedure or treatment performed in a hospital designated by Aetna as the most appropriate facility.

***Non-formulary brand name drug*** – A prescription drug protected by trademark registration, but not included in the CVS Caremark formulary listing. These drugs typically have an equally effective and less costly generic equivalent.

***Non-occupational disease*** – A disease that does not result in any way from work for pay or profit. If you are covered under any workers' compensation law, a disease will also be considered non-occupational if it is not covered under that law.

***Non-occupational injury*** – An accidental bodily injury that does not result in any way from work for pay or profit.

***Nurse*** – A registered nurse (RN) or licensed practical nurse (LPN), if licensed for the services provided in the state where he or she practices.

***Out-of-network provider (Non-preferred provider)*** – A state licensed health care provider who does not have an agreement with Aetna.

***Out-of-pocket maximum*** – A set limit to the amount of money that a team member must pay out of his or her own funds each plan year for covered health care expenses. Once this limit is met, the health plan pays 100% of the team member's covered health care expenses for the remainder of the plan year. Charges above reasonable and customary limits, if applicable, are not covered expenses and do not count toward the out-of-pocket maximum. Using in-network providers will usually reduce your out-of-pocket expenses.

***Participating pharmacy (Network pharmacy)*** – A pharmacy that has contracted with CVS Caremark to provide prescription services.

***Plan year*** – The 12-month period beginning on July 1 and ending on June 30 of the following year, for which benefit elections are effective.

***Primary care physician (PCP)*** – A preferred provider selected by an Aetna Silver Medical Plan member to provide and coordinate his or her ongoing health care.

***Psychiatric physician*** – A physician who specializes in psychiatry or has the training and/or experience to evaluate and treat mental illness.

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

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

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

- For professional services and for other services or supplies not mentioned below:
  - The reasonable amount rate

The recognized charge is the negotiated charge for providers with whom we have a direct contract but are not network providers or, if there is no direct contract, with whom we have a contract through any third party that is not an affiliate of Aetna.

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

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

Aetna reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of physicians and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used

Geographic area and Reasonable amount rate are defined as follows:

Geographic area

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

Reasonable amount rate:

There is not a single “reasonable” amount. Your plan establishes the “reasonable” amounts as follows:

- For professional services:
  - The XXth percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we reserve the right to substitute an alternative. If the alternative data source does not contain a value for a particular service or supply, we will base the **recognized charge** on the Medicare allowable rate.

**Additional information:**

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

***Residential Treatment Facility (Mental Disorders)***

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

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care must be consistent with the patient’s illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Mental Health Residential Treatment Programs:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a psychiatrist at least once per week; and
- The medical director must be a psychiatrist.

***Residential Treatment Facility (Substance Abuse)***

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

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- Is a behavioral health provider or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a physician who is an addiction specialist.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An R.N. is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a physician.

***R.N. -*** A registered nurse.

***Room and board charges*** – Charges made regularly by an institution (at a daily or weekly rate) for board and room and other medically necessary services and supplies.

***Routine physical exam*** – A medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury.

***Semi-private rate*** – The daily rate for room and board that an institution charges for most beds in its semiprivate rooms (two or more beds). If an institution does not have semiprivate rooms, Aetna will determine the rate based on the semiprivate rate typically charged by similar institutions in the same geographic area.

***Specialist*** – A physician who practices in any generally accepted medical or surgical sub-specialty and provides care other than routine medical care.

***Specialty medications:*** Specialty medications are defined as certain pharmaceutical and/or biotech or biological drugs (including "biosimilars" or "follow-on biologics") which are used in the management of chronic or genetic disease, including but not limited to, injectables, infused, inhaled or oral medications, or otherwise require special handling.

***Surgery center*** – A public or private facility, licensed and operated according to law, with an organized staff of physicians equipped to perform surgery. Both a physician and a registered nurse (RN) must be on the premises when surgery is performed. Surgery centers do *not* provide services or accommodations for overnight stays.

***Terminally ill*** – A medical prognosis of 24 months or less to live.

***Urgent admission*** – When a physician admits a patient to the hospital as the result of a condition – the onset or diagnosis of a disease, a change in a disease or an injury caused by an accident – that is not an emergency, but is severe enough to require hospitalization within two weeks from the date the condition is identified.

***Urgent Care Facility***

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.

***Urgent Care Provider***

- A freestanding medical facility that meets all of the following requirements.
- Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
- Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
- Charges for its services and supplies.
- Is licensed and certified as required by any state or federal law or regulation.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians. At least one physician must be on call at all times.
- Has a full-time administrator who is a licensed physician.
- A physician's office, but only one that:
- Has contracted with Aetna to provide urgent care; and
- Is, with Aetna's consent, included in the directory as a network urgent care provider.

***Urgent condition*** – A sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health
- Would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment
- Does not require the level of care provided in the emergency room of a hospital

  *and*
- Requires immediate outpatient medical care that cannot be postponed until the covered person's physician becomes reasonably available.

***Walk-in clinic*** – A freestanding health care facility, used as an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician.