State of New Jersey

AETNA MEMBER HANDBOOK

Aetna HMO Plan

FOR EMPLOYEES AND RETIREES
ENROLLED IN THE
STATE HEALTH BENEFITS PROGRAM
OR
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

Department of the Treasury
Division of Pensions and Benefits

PLAN YEAR
2016

WELCOME!

Our goal is your good health. To achieve this goal, we encourage preventive care in addition to covering you when you are sick or injured. An extensive network of participating physicians and hospitals is available to provide you with easy access to medical care 24 hours a day, 7 days a week.

We believe that through the appropriate use of health resources, we can work together to keep you healthy and to control the rising costs of medical care for everyone.

Your Health Maintenance Organization (HMO) benefits programs are self-funded by your employer and administered by Aetna Life Insurance Company (Aetna).

An online version of this handbook containing current updates is available for viewing over the Division of Pensions and Benefits Web site at: ***www.nj.gov/treasury/pensions/***

Be sure to check the Web site for related forms, fact sheets, and news of any developments affecting the benefits provided under the State Health Benefits Program (SHBP) or the School Employees' Health Benefits Program (SEHBP).

You can also check the custom Aetna Web site at: ***www.aetnastatenj.com*** for medical and dental plan documents, discount program information, and numerous other helpful resources.

Every effort has been made to ensure the accuracy of the Aetna Member Handbook, which describes the benefits provided and is an amendment to the contract with Aetna, Inc. However, State law and the New Jersey Administrative Code govern the SHBP and the SEHBP. If there are discrepancies between the information presented in this handbook, and the law, regulations, or contract, the latter will govern.

We wish you the best of health.

YOUR MEMBER HANDBOOK

This member handbook is your guide to the benefits available through the Aetna HMO Plans and Aetna Medicare Plans (HMO). Please read it carefully and refer to it when you need information about how the plan works, what to do in an emergency situation, and what benefits are covered. It is also an excellent source for learning about many of the special programs available to you as an Aetna plan participant.

If you cannot find the answer to your question(s) in the member handbook, call the Member Services toll-free number. Aetna HMO members should call: 1-877-STATE NJ (782-8365). Aetna Medicare Plan (HMO) members should call 1-866-234-3129. These numbers are also listed on your identification card (ID). A trained representative will be happy to help you. For more information, go to the "Member Services" section later in this book.

Tips for New Plan Participants

- Keep this booklet where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Post your Primary Care Physician's name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See "In Case of Medical Emergency" (on page 22) for emergency care guidelines.

TABLE OF CONTENTS

AETNA HMO PLANS: OVERVIEW

Aetna HMO is available to all employees and retirees without Medicare residing in New Jersey, Delaware, Florida, New York, Maryland, and Pennsylvania. **Aetna Select** is available to retirees without Medicare residing outside of New Jersey, Delaware, Florida, New York, Maryland, and Pennsylvania.

There are 3 HMO options:

- Aetna HMO
- Aetna HMO1525 *(For retirees and Active Education employees only)*
- Aetna HMO2030 *(For Non-Medicare retirees and Active Education employees only)*
- Aetna HMO2035 (*For Active Education employees only*)

Medicare-eligible Retirees enrolled in Aetna and their dependents that are eligible for Medicare are enrolled in the Aetna Medicare Plan (HMO). Members must reside in an Aetna Medicare Plan (HMO) service area. If you live outside of an Aetna (HMO) Service area, please view our Aetna PPO handbook for information on other Medicare options available. The Aetna Medicare Plan (HMO), not original Medicare, is the primary payer.

There are 2 Medicare Advantage HMO options:

- Aetna Medicare Advantage HMO
- Aetna Medicare Advantage HMO1525

The Primary Care Physician

Aetna participants have access to a network of participating Primary Care Physicians, specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

Each participant in the HMO Plan must select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system and will help you access appropriate care. The PCP may be an internist, family doctor, pediatrician, or general practitioner. You may change your PCP selection at any time by calling Aetna Member Services or via Aetna Navigator. PCPs provide routine care for illness, injury, and preventive care such as periodic physical examinations, eye exams, well-baby visits, and immunizations.

As a participant in **Aetna HMO,** you will become a partner with your participating Primary Care Physician in preventive medicine. Consult your Primary Care Physician whenever you have questions about your health. Your Primary Care Physician will provide your care and will refer you to specialists or facilities for treatment when medically necessary. The referral is important because it is how your Primary Care Physician arranges for you to receive necessary, appropriate care and follow-up treatment. Except for PCP, direct access, routine services and emergencies, **you must have a prior written or electronic referral from your Primary Care Physician.** Participating specialists are required to send reports back to your Primary Care Physician to keep your Primary Care Physician informed of any treatment plans ordered by the specialist.

The Aetna Medicare Plan (HMO) does not require the selection of a Primary Care Physician; however, it is strongly encouraged. You must use providers who participate in the Aetna Medicare Plan (HMO) network. Before receiving services, you should contact your provider directly to verify that he or she participates in the network. You may also call Aetna directly at 1-866-234-3129, and a Customer Service Representative will be glad to assist you.

No referrals are needed when an Aetna Medicare Plan (HMO) member seeks care from a participating provider. Precertification may be required for some services. Retirees enrolled in the Aetna Medicare Plan (HMO) receive an identification card that indicates they are in the Aetna Medicare Plan (HMO). You should present your Aetna Medicare Plan (HMO) ID card, not your original Medicare ID card, when receiving medical services (refer to Your ID Card section for more information).

Primary and Preventive Care

Your Primary Care Physician can provide preventive care and treat you for illnesses and injuries. The Primary Care Physician can also order lab tests and x rays, prescribe medicines or therapies, and arrange hospitalization. The plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your Primary Care Physician. You may also obtain routine gynecological exams from participating providers without a referral from your Primary Care Physician.

Specialty and Facility Care

Aetna HMO Participants

Your Primary Care Physician may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary. **Members must have a prior written or electronic referral from your Primary Care Physician to receive coverage for any services the specialist or facility provides** except for direct access benefits (routine gynecological, routine mammography, routine eye exams) and emergency services.

When your Primary Care Physician refers you to a participating specialist or facility for covered services, you will be responsible for the applicable copayment.

Aetna Medicare Advantage HMO members do not need a referral as this HMO plan is considered an Open Access plan.

Follow these steps to avoid costly and unnecessary bills:

- **Consult your Primary Care Physician first** when you need routine medical care. If your Primary Care Physician deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. For direct access benefits, you may contact the participating provider directly, without a referral.
- Certain services require both a referral from your Primary Care Physician and prior authorization from Aetna. Your Primary Care Physician is responsible for obtaining authorization from Aetna for in-network covered services.
- **Review the referral** with your Primary Care Physician. Understand what specialist services are being recommended and why.
- Present the referral to the participating provider. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services.**

- If it is not an emergency and you go to a doctor or facility **without your** Primary Care Physician's **prior written or electronic referral, you must pay the bill yourself.**
- Your Primary Care Physician may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by Aetna in addition to a special nonparticipating referral from your Primary Care Physician. When properly authorized, these services are covered after the applicable copayment.

Remember: You cannot request referrals **after** you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your Primary Care Physician and get authorization from Aetna (when applicable) **before** seeking specialty or hospital care.

Provider Information

As a member of an Aetna Plan, you may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Member Services number on your ID card.

It is easy to obtain information about providers in Aetna's network using the Internet. With DocFind® you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind® customized for SHBP and SEHBP members, go to: ***www.aetna.com/docfind/custom/statenj*** Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation.

Aetna Medicare Plan (HMO) members can visit any provider who participates in the Aetna Medicare Plan (HMO) network. You can contact Aetna Member Services as 1-866-234-3129 for assistance in locating a provider who participates in the Aetna Medicare Plan (HMO) network. You may also visit DocFind® .

Your ID Card

When you join an **Aetna HMO** or the **Aetna Medicare Plan (HMO)** you will receive an ID card. Your ID card lists the telephone number of the Aetna Primary Care Physician you have chosen (if applicable). If you change your Primary Care Physician, you will automatically receive a new card displaying the change.

Always carry your ID card(s) with you. It identifies you as an Aetna participant when you receive services from participating providers or when you receive emergency services at nonparticipating facilities.

If your ID card is ever lost or stolen, please notify Aetna immediately by phone or through the Internet. You may wish to print a temporary ID card through Aetna Navigator®. Please refer to the Aetna Navigator® section for more information.

HMO PLANS COPAYMENT SCHEDULE

Unless otherwise indicated in the following chart:

- The **copayment for State employees in Aetna HMO** is $15 per visit to a Primary Care Physician (PCP) or referred specialist.
- The **copayment for Local Government, Local Educational employees,** and **All Retirees in Aetna HMO** is $10 per visit to a PCP or referred specialist.
- The **copayments for Education Employees and Retirees in the Aetna HMO1525** plan are $15 per visit to a PCP or $25 per visit to a specialist.
- The **copayments for Education Employees and Retirees in the Aetna HMO2030** plan are $20 per visit to a PCP or $30 per visit to a specialist. **Please note** that children age 26 and younger will only pay $20 for specialist visits (this only applies to dependent children, not spouses).
- The **copayments for Education Employees in the Aetna HMO2030** plan are $20 per visit to a PCP or $35 per visit to a specialist.
- The **copayment for Medicare eligible Retirees in the Aetna Medicare Advantage Plan (HMO)** is $10 per visit to a PCP or specialist.
- The **copayments for Medicare eligible Retirees in the Aetna Medicare Advantage 1525 Plan (HMO)** are $15 per visit to a PCP or $25 per visit to a specialist.

All non emergency specialty and hospital services require a prior referral from your Primary Care Physician for the Aetna HMO plans, unless otherwise noted in the chart below as a “direct access” benefit. Referrals are not required for the Aetna Medicare Plans (HMO).

Type of Service or Supply	Benefit Level
Maximum Benefit	Unlimited
Annual Maximum Out-of-Pocket	***HMO Active Employee (State, Local Government, & Education):*** $5,480 (Individual) and $10,960 (family) **HMO Retiree (State & Local Government):** $5,499 (Individual) and $10,998 (Family) **HMO Retiree (Education):** $5,317 (Individual) and $10,634 (Family) ***Medicare HMO:*** $2,500 (Individual)
Deductible	***HMO, HMO1525, HMO2030***: No deductible ***HMO2035:*** $200 (Individual) and $500 (Family) ***Medicare HMO:*** No deductible

Type of Service or Supply	Benefit Level
Primary and Preventive Care	
PCP Office Visits	Copayment applies per visit
After Hours/Home Visits/Emergency	Copayment applies per visit
Routine Well-Adult Examinations	***HMO:*** No copayment - 1 routine exam per 12 months for age 22 and over. ***Medicare HMO:*** No copayment - 1 routine exam every 12 months
Routine Well-Baby Care	***HMO:*** No copayment - 7 exams in the first 12 months - 3 exams when child is 13-24 months
Routine Well-Child	***HMO:*** No copayment - 3 exams when child is 25-36 months - 1 exam per 12 months when child is 37 months through age 21
Immunizations	No copayment
Routine Gynecological Exams – direct access (no referral) to participating provider	**HMO:** No copayment – 1 routine OB/GYN visit and pap smear every 12 months for females age 21 and over **Medicare HMO:** No copayment – 1 routine GYN visit and pap smear every 24 months
Routine Mammogram – direct access (no referral) to participating provider	**HMO:** No copayment – no age or frequency limits **Medicare HMO:** No copayment – 1 baseline mammogram for members 35-39; and 1 annual mammogram for members age 40 and over
Routine Prostate Cancer Screenings	**HMO:** No copayment – covered for males, no frequency or age limitations apply **Medicare HMO:** No copayment – covered for males age 50 and over every 12 months
Colorectal Cancer Screening – Colorectal cancer screening standards apply to members age 50 or older in accordance with the American Cancer Society guidelines for all members 50 years of age or older.	No copayment

Type of Service or Supply	Benefit Level
Routine Eye Examination – direct access (no referral) to participating providers – 1 exam per 12 months	**HMO:** Copayment applies per visit **Medicare HMO:** No copayment
Tobacco Cessation Preventive Counseling – limited to 8 visits per 12 months	No Copayment
Alcohol/Drug Preventive Counseling – limited to 5 visits per 12 months	No Copayment
Obesity Preventive Counseling — **- Age 0–22 unlimited visits** **- Age 22 and over – 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling**	No copayment
Hearing Aids	**HMO:** Not covered – except for members 15 years old or younger in accordance with Grace's Law
Specialty and Outpatient Care	
Specialist Office Visits	Copayment applies per visit
Prenatal Care:	
First OB visit	Copayment applies
Subsequent Prenatal Visits	No copayment
Infertility Services:	
Diagnosis	Copayment applies per visit
Treatment – with limitations	Copayment applies per visit
Advanced Reproductive Technology	Copayment applies per visit
Allergy Testing	Copayment applies per visit
Allergy Treatment – Injections at PCP's office, with or without physician encounter	Copayment applies per visit
Diagnostic (X-ray and Lab Tests)	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment

Type of Service or Supply	Benefit Level
Outpatient Therapy – Speech, Occupational, Physical	**HMO:** Copayment applies per visit **Medicare HMO:** Copayment applies per visit
Chiropractic Care	**HMO, HMO1525, HMO2030:** Copayment applies per visit – limit of 20 medically necessary visits per calendar year **HMO2035:** Copayment applies per visit – limit of 30 medically necessary visits per calendar year **Medicare HMO:** Copayment applies per visit
Home Health Care	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Hospice Care	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** Copayment applies **Medicare HMO:** Not covered (Covered by Medicare at a Medicare certified hospice)
Durable Medical Equipment (DME)	**HMO, HMO1525, HMO2030:** 100% after $100 DME deductible per calendar year – DME Out-of-Pocket Maximum $100 per individual, per calendar year **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Prosthetic Devices	**HMO, HMO1525, HMO2030:** 100% after $100 deductible per calendar year – combined deductible with DME (above) **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Orthotic Devices	**HMO:** not subject to $100 special DME deductible **Medicare HMO:** No copayment – covered at 100% for specific diagnoses
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Skilled Nursing Facilities – 120 days per calendar year	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment

Type of Service or Supply	Benefit Level
Hospice Facility	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** Not covered (Covered by Medicare at a Medicare certified hospice)
Inpatient Physician Visits	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Surgery and Anesthesia	
Inpatient Surgery	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Outpatient Surgery	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Maternity	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Mental and Nervous Conditions	
Inpatient Treatment – No maximum number of days	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Outpatient Treatment – No maximum number of days	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** Specialist copay applies **Medicare HMO:** No copayment

Type of Service or Supply	Benefit Level
Treatment of Alcohol and Drug Abuse	
Inpatient Treatment	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Inpatient Detoxification	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Inpatient Rehabilitation	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment
Outpatient Treatment	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** Specialist copay applies **Medicare HMO:** No copayment
Outpatient Detoxification	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** Specialist copay applies **Medicare HMO:** No copayment
Emergency Care	
Hospital Emergency Room (Copayment waived if admitted)	**HMO:** **Aetna HMO for State Employees –** $75 copayment **HMO:** **Aetna HMO for State Retirees & Local Government Employees & Retirees –** $60 copayment **HMO:** **Aetna HMO for Local Education Employees –** $35 copayment **HMO1525 (Education):** $75 copayment **HMO1525 (State & Local Gov't Retirees):** $100 copayment **HMO2030:** $125 copayment **HMO2035 (Education):** $300 copayment **Medicare HMO:** $60 copayment **Medicare HMO1525:** $75 copayment
Urgent Care Facility	Specialist copayment applies
Ambulance	**HMO, HMO1525, HMO2030:** No copayment **HMO2035:** 20% coinsurance after deductible is met **Medicare HMO:** No copayment

YOUR BENEFITS

Although a specific service may be listed as a covered benefit, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of your illness or condition. Refer to the "Glossary" section for the definition of "medically necessary."

For HMO members, certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval.

Under the Aetna Medicare Plan (HMO), precertification may be required for some services. A provider can always request precertification. Providers can obtain precertification by calling the Provider Services number on the back of your Aetna Medicare Plan (HMO) ID card.

Primary and Preventive Care

One of the Plan's goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan if provided by your Primary Care Physician or on referral (if applicable) from your Primary Care Physician.

Primary and Preventive services include:

- Office visits with your Primary Care Physician during office hours and during non-office hours.
- Home visits by your Primary Care Physician.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your Primary Care Physician. Routine physical examinations include, but are not limited to, employer-mandated physical examinations that are prerequisite to participation in a physical fitness test that is required as a condition of continuing employment.
- Well-child care from birth, including immunizations and booster doses, as recommended by your Primary Care Physician.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Routine gynecological examinations and Pap smears.
- Annual mammography screening for asymptomatic women age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their Primary Care Physician.

Note: *Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.*

- Routine immunizations (except those required for travel or work).
- Annual eye examinations.
- Routine hearing screenings performed by your Primary Care Physician as part of a routine physical examination.

- Obesity Preventive Counseling:
  - For ages 0-21 there is no copay for Obesity Preventive Counseling, which includes the Healthy Diet Counseling benefit. The number of visits are unlimited;
  - For ages 22 and over there is no copay for Obesity Preventive Counseling, which includes the Healthy Diet Counseling benefit. There is a maximum of 26 visits in one year, 10 of which may be used for Healthy Diet Counseling.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services. If you are an Aetna HMO Plan member, you must have a prior written or electronic referral from your Primary Care Physician in order to receive coverage for any non emergency services the specialist or facility provides. If you are an Aetna Medicare Plan (HMO) member, referrals are not required.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Autism or another developmental disability – Effective February, 8, 2010, Chapter 115, P.L. 2009, requires that the SHBP/SEHBP provide:
  - Coverage for expenses incurred in screening and diagnosing autism or another developmental disability;
  - Coverage or expenses incurred for medically necessary physical therapy, occupational therapy and speech therapy services for the treatment of autism or another developmental disability;
  - Coverage for expenses incurred for medically necessary behavioral interventions (ABA therapy) for individuals under 21 years of age diagnosed with autism;
  - A benefit for the Family Cost Share portion of expenses incurred for certain health care services obtained through the New Jersey Early Intervention System (NJEIS).

  There is no dollar benefit maximum for ABA therapy services per year for children with autism. ABA therapy is not eligible for children with developmental diagnoses.

  Aetna Behavioral Health must be contacted to precertify ABA services for autistic children.

  Aetna HMO Utilization Management must be contacted for precertification by the provider requesting occupational therapy, speech, and physical therapy services.

- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service – 24 hours a day, 7 days a week (see "In Case of Emergency" on page 22).
- Hearing Aids – Effective March 30, 2009, in accordance with Grace's Law coverage will be provided for medically necessary expenses incurred in the purchase of a hearing aid for covered members who are 15 years old or younger. Coverage is provided for the purchase of a hearing aid for each hearing impaired ear once in a 24-month period, when it is medically necessary and prescribed by a licensed physician or audiologist. Benefits during each 24-month period are limited to the cost of the hearing aid, up to $1,000 for each hearing impaired ear. If a higher priced hearing aid is selected, the member is responsible for the amount that is greater than $1,000.
- Home health services provided by a participating home health care agency, including:
  - Skilled nursing services provided or supervised by an RN.
  - Services of a home health aide for skilled care.
  - Medical social services provided or supervised by a qualified physician or social worker if your Primary Care Physician certifies that the medical social services are necessary for the treatment of your medical condition.
  - Private Duty Nursing (PDN) when rendered at home. There is no outpatient limit on PDN services. Medical necessity does apply and custodial care is not covered.
- Outpatient hospice services for a Plan participant who is terminally ill, including:
  - Counseling and emotional support.
  - Home visits by nurses and social workers.
  - Pain management and symptom control.
  - Instruction and supervision of a family member.

  Note: *The Plan does* ***not*** *cover the following hospice services:*
  - Bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
  - Homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
  - Respite care when the patient's family or usual caretaker cannot, or will not, attend to the patient's needs.

  Hospice care means a program of care that is:
  - Provided by a hospital, skilled nursing facility, hospice or duly licensed hospice care agency;
  - Approved by Aetna; and
  - Focused on palliative rather than curative treatment for a Plan participant who has a medical condition and a prognosis of less than 6 months to live.
- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, removal of tumors and orthodontogenic cysts).

- Accidental dental injuries if medically necessary. You must have been covered by Aetna at the time the injury occurred. An accidental dental injury is considered an injury to teeth (must be sound natural teeth) which is caused by an external factor such as damage caused by being hit by a hockey puck or having teeth broken in a fall on the ice. The treatment and replacement must occur within 12 months of the accident. A treatment plan must be submitted. If it is determined that treatment cannot be reasonably completed within 12 months, this time limit may be extended. Breaking a tooth while chewing on food is not considered an accidental dental injury. Stress fractures in teeth are very common and generally undetectable by X-ray. Stress fractures are often the cause of tooth breakage. Treatment for this type of tooth breakage is considered a dental service and not eligible for reimbursement.
- Reconstructive breast surgery following a mastectomy, including:
  - Reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
  - Surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
  - Physical therapy to treat the complications of the mastectomy, including lymphedema.
- Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X rays performed by a participating radiologist. 20 visit calendar year maximum applies.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Prosthetics require preauthorization by Aetna and are covered according to the New Jersey State mandate.
  - Orthotics are not subject to the $100 special Durable Medical Equipment deductible. This is covered per the New Jersey State mandate.
- Inherited Metabolic Disease medical food, certain non-standard infant formula (under one year of age).
- Scalp Hair Prostheses – Maximum benefit of $500 in a 24-month period, per person, for scalp hair prostheses (wig) prescribed by a doctor, only if they are furnished in connection with hair loss resulting from:
  - Treatment of disease by radiation or chemicals;
  - Alopecia Universalis (totalis); or
  - Alopecia Areata.
- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury, and preauthorized by Aetna.

  The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:
  - They are needed due to a change in your physical condition, or
  - It is likely to cost less than repair of the existing equipment or to rent similar equipment.

  The request for any type of DME must be made by your physician, pre-authorized and coordinated through the Aetna Patient Management Department.

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice

If you are hospitalized by a participating Primary Care Physician or specialist (with prior referral except in emergencies), you are eligible for the following covered services listed below. See “Behavioral Health” section for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your Primary Care Physician) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Use of intensive or special care facilities.
- Visits by your Primary Care Physician while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Application of medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered if it has been donated or replaced on behalf of the patient.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
  - Cardiac rehabilitation, and
  - Pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Use of magnetic resonance imaging (MRI).
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an IOE network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Women's Health and Maternity

Due to Health Care Reform changes, effective January 1, 2013, more information pertaining to Women's Preventive Health is available on the Aetna website at ***www.aetnastatenj.com***

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section).

However, your provider may – **after consulting with you** – discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

You do not need a referral from your Primary Care Physician for visits to your participating obstetrician. A list of participating obstetricians can be found in your provider directory or on DocFind (see "Provider Information" section).

Note: *Your participating obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care after your first visit. They must request approval (precertification) for any tests performed outside of their office and for visits to other specialists. Please verify that the necessary referral has been obtained before receiving such services.*

If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers **on and after your Effective Date of enrollment.** There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Infertility Treatment

Aetna will follow the New Jersey State Mandate for Infertility.

Charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed are covered. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy (including microsurgical sperm aspiration); laboratory tests; sperm washing or preparation; diagnostic evaluations; assisted hatching; fresh and frozen embryo transfer; ovulation induction; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF), including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier; zygote intrafallopian transfer (ZIFT); artificial insemination; intracytoplasmic sperm injection (ICSI); and the services of an embryologist. This benefit includes diagnosis and treatment of both male and female infertility.

Eligibility Requirements

Infertility services are covered for any abnormal function of the reproductive systems such that you are not able to:

- Impregnate another person;
- Conceive after two years if the female partner is under 35 years old, or after one year if the female partner is 35 years old or older, or if one partner is considered medically sterile; or
- Carry a pregnancy to live birth.

In vitro fertilization, gamete transfer and zygote transfer services are covered only:

- If you have used all reasonable, less expensive and medically appropriate treatment and are still unable to become pregnant or carry a pregnancy;
- Up to four completed egg retrievals combined, per lifetime (including those covered under prior plans, but not those provided at your expense); and
- If you are 45 years old or younger.

Covered Expenses

- Where a live donor is used in the egg retrieval, the medical costs of the donor shall be covered until the donor is released from treatment by the reproductive endocrinologist;
- Egg retrievals where the cost was not covered by any carrier shall not count in determining whether the four completed egg retrieval limit has been met;
- Intracytoplasmic sperm injections;
- In vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier;
- Prescription medications, including injectable infertility medications, are covered under the SHBP/SEHBP's Prescription Drug Plans. Private freestanding prescription drug plans arranged by local employer groups are required to be comparable to the SHBP/SEHBP Prescription Drug Plans and must provide coverage for infertility medications for covered members and donors;
- Ovulation induction;
- Surgery, including microsurgical sperm aspiration;
- Artificial Insemination;
- Assisted Hatching;
- Diagnosis and diagnostic testing; and
- Fresh and frozen embryo transfers.

Exclusions

The following are specifically excluded infertility services:

- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Non-medical costs of an egg or sperm donor. Medical costs of donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist;
- Cryopreservation is not a covered benefit;
- Any experimental, investigational or unproven infertility procedures or therapies.
- Payment for medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by the carrier's policy or contract;
- Ovulation kits and sperm testing kits and supplies;

- In vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer for persons who have not used all reasonable, less expensive, and medically appropriate treatments for infertility, who have exceeded the limit of four covered completed egg retrievals, or are 46 years of age or older; and
- The number of covered embryo transfers are limited by the number of eggs retrieved in the lifetime maximum of four completed egg retrievals.

Family Planning (Contraception Services)

Brand contraceptive devices may be excluded from the formulary and/or include copayments as long as a therapeutically equivalent generic contraceptive device is available on formulary as preventive care.

Other contraceptives may be covered as part of your prescription drug program. Refer to the separate member handbook describing your prescription drug coverage for more information.

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. You do not need a referral from your Primary Care Physician to obtain care from participating mental health and substance abuse providers. Instead, when you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Mental Health Treatment

The Plan covers the following services for mental health treatment:

- Inpatient medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.
- Short-term evaluation and crisis intervention mental health services provided on an **outpatient** basis.

Treatment of Alcohol and Drug Abuse

The Plan covers the following services for treatment of alcohol and drug abuse subject to plan maximums:

- **Inpatient** care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- **Inpatient** medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an appropriately licensed facility.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your Primary Care Physician.
- **Outpatient** visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.

  Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

Plan Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by Aetna.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Charges for canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
  - Reconstructive surgery to correct the results of an injury.
  - Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
  - Surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your Primary Care Physician.
- Custodial care and rest cures.
- Dental care and treatment.
- Educational services, special education, remedial education or job training. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.

This exclusion will not apply to drugs:

- That have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
- That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
- That Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.

Refer to the "Glossary" for a definition of "experimental or investigational."

- False teeth.
- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids (except as described in the "Specialty and Outpatient Care" section), eyeglasses, or contact lenses or the fitting thereof.
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work.
- Implantable drugs.
- Inpatient private duty or special nursing care in any type of facility.
- Maintenance Care: Care that when provided does not substantially improve the condition. When care is provided for a condition that has reached maximum improvement and further services will not appreciably improve the condition, care will be deemed to be maintenance care and no longer eligible.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision.)
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies purchased over the counter such as syringes, incontinence pads, elastic stockings and reagent strips.
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.

- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services, and immunizations in connection with:
  - Obtaining or continuing employment,
  - Obtaining or maintaining any license issued by a municipality, state or federal government,
  - Securing insurance coverage,
  - Travel, and
  - School admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.

  This exclusion does not apply to employer-mandated physical examinations that are prerequisite to participation in a physical fitness test that is required as a condition of continuing employment.
- Services and supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- 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.
- Speech therapy for treatment of delays in speech development except when deemed medically necessary for a member with autism or PDD.
- Supportive Care: Care for patients having reached the maximum therapeutic benefit in which periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. Supportive care services, even those that are considered to be medically needed, are not covered.
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):
  - Primal therapy.
  - Chelation therapy, except for heavy metal poisoning.
  - Rolfing.
  - Psychodrama.
  - Megavitamin therapy.
  - Purging.
  - Bioenergetic therapy.
  - Vision perception training.
  - Carbon dioxide therapy.
- Thermograms and thermography.

- Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual.
- Treatment of occupational injuries and occupational diseases, including injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
  - Treatment performed by placing a prosthesis directly on the teeth,
  - Surgical and non-surgical medical and dental services, and
  - Diagnostic or therapeutic services related to TMJ.
- Weight reduction programs and dietary supplements.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance.

Prescription Drug Benefits

The State Health Benefits Commission and School Employees' Health Benefits Commission require that all covered employees and retirees have access to prescription drug coverage. Please refer to the separate handbook describing your prescription drug program for detailed information about prescription drug coverage.

The Commissions reserve the right to establish dispensing limits on any medication based on Food and Drug Administration (FDA) recommendations and medical appropriateness. Prior Authorization, Drug Utilization Review, Dose Optimization, Step Therapy, Preferred Drug Step Therapy (PDST)* and the Specialty Pharmacy Program are employed to ensure that the medications that are reimbursed under the plan are the most clinically appropriate and cost effective.

Volume restrictions also apply to certain drugs such as sexual dysfunction drugs (Viagra, etc.). Certain drugs that require administration in a physician's office may be covered through your medical plan.

**PDST does not apply to certain State employees and their dependents*

In Case of Medical Emergency

Guidelines

If you need emergency care, you are covered 24-hours a day, 7 days a week, anywhere in the world. Aetna has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

Some examples of emergencies are:

- Heart attack or suspected heart attack.
- Poisoning.
- Severe shortness of breath.
- Uncontrolled or severe bleeding.
- Suspected overdose of medication.
- Severe burns.
- High fever (especially in infants).
- Loss of consciousness.

Whether you are in or out of Aetna's service area, we ask that you follow the guidelines below when you believe you may need emergency care.

1. Call your Primary Care Physician (PCP) first, if possible. Your PCP is required to provide urgent care and emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility, or dial 911 or your local emergency response service.
2. After assessing and stabilizing your condition, the emergency facility should contact your PCP so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible. The emergency room copayment will be waived if you are admitted to the hospital.
4. All follow-up care must be coordinated by your PCP.
5. If you go to an emergency facility for treatment that Aetna determines is non-emergency in nature, you will be responsible for the bill. The Plan does not cover non-emergency use of the emergency room.

Follow Up Care after Emergencies

All follow up care should be coordinated by your PCP. You must have a referral from your PCP **and** approval from Aetna to receive follow-up care from a nonparticipating provider. Whether you were treated inside or outside your Aetna service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit;
- You could not reasonably have anticipated the need for the care prior to leaving the network service area; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Urgent care from participating providers within your service area is covered if your PCP is not reasonably available to provide services to you. You should first seek care through your PCP. Referrals to participating urgent care providers are not required, but the care must be urgent, non-preventive or non-routine.

Some examples of urgent medical conditions are:

- Severe vomiting.
- Sore throat.
- Earaches.
- Fever.

Follow up care provided by your PCP is covered, subject to the office visit copayment. Other follow-up care by participating specialists is fully covered with a prior written or electronic referral from your PCP, subject to the specialist copayment shown in the "Copayment Schedule".

What to Do Outside Your Aetna Service Area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk in clinic, or an urgent care center. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings. You should call your PCP before receiving treatment from a non-participating urgent care provider.

If, after reviewing information submitted to Aetna by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an *Emergency Room Notification Report* or a Customer Service Professional can take this information over the telephone.

Special Programs

The Aetna Discount Program

From time to time, Aetna may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, dentists, alternative medicine, wellness and healthy living providers to persons covered under the plan. Some of these arrangements may be made available through third parties who may make payments to Aetna in exchange for making these services available. The third party service providers are independent contractors and are solely responsible to covered persons for the provision of any such goods and/or services. Aetna reserves the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to covered persons nor does Aetna compensate providers for services they may render. **All Aetna Discount Programs can be located on Aetna Navigator which can be accessed at *www.aetnastatenj.com***

At Home Products

Looking to save money for your home and family? You can get discounts on a variety of products and services such as the Omron 7 Series™ Upper Arm Deluxe Blood Pressure Monitor. Track your blood pressure when you need to, accurately and easily.

Natural Products and Services

Few people travel the same path to good health. With the natural products and services discounts, you and your family can save on specialty health care products and services, including online consultations.

- The ChooseHealthy®* program: You'll get a discount off standard charges for acupuncture, chiropractic, massage therapy and nutrition services. And get a discount off the manufacturer's suggested retail price of health and wellness products.
- Vital Health Network: You can get a discount off the retail price of an online consultation with a Vital Health Network doctor for one topic. Then, save additionally off the retail price of an online consultation for additional topics.

**The ChooseHealthy program is made available through American Specialty Health Systems, Inc. (ASH Systems), a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.*

For more information or to locate participating natural therapy professionals, call the Member Services number on your ID card or visit the Aetna Natural Products and Services discount program page in Aetna Navigator by logging onto our secure member website at ***www.aetnanavigator.com***

Fitness

Regular exercise can help you maintain a healthy weight, look and feel better. It can also lower your risks for:

- Alzheimer's disease
- Depression and anxiety
- Diabetes
- Heart disease
- High blood pressure

Save on gym memberships* and name-brand home fitness and nutrition products that support your healthy lifestyle with services provided by GlobalFit®.

**Participation is for new gym members only. If you belong to a gym now, or belonged recently, call GlobalFit to see if a discount applies.*

For more information, call the Member Services number on your ID card or visit the Aetna Fitness discount program page in Aetna Navigator by logging onto our website at ***www.aetnanavigator.com*** You can also contact GlobalFit directly at 1-800-298-7800.

Vision

With Aetna's vision discounts offered through EyeMed Vision Care, you can save on eye exams, eyeglass frames and lenses, contact lenses and solutions, prescription and non-prescription sunglasses, LASIK surgery and more. You can also get discounts on replacement contact lenses.

Hearing

Find out if you suffer from hearing loss and save on a top-quality hearing aid if it becomes necessary. You can also get discounts on hearing exams, hearing aids, batteries, repairs and other hearing aid services from Amplifon Hearing Health Care (formerly HearPO®) and Hearing Care Solutions.

Weight Management

You can meet your weight loss goals and save money by choosing from many programs and plans. So get started, lose weight, feel better and develop a balanced, managed approach to your active lifestyle!

Save on the CalorieKing® Program* and products, Jenny Craig® weight loss programs** and Nutrisystem® weight loss meal plans***. With all programs and plans, enjoy one-on-one help, personalized menus, online tools, chat rooms and more.

**If you are already a CalorieKing member and want to get the Aetna discounted membership price, you will need to terminate your current CalorieKing account and rejoin.*

***Plus the cost of food. Plus the cost of shipping (if applicable). Offer applies to initial enrollment fee only and is valid only at participating Centers and through Jenny Craig At Home. Each offer is a separate offer and can be used only once per Member. No cash value. Restrictions apply.*

****The Aetna discount offers do not apply to any plan in which you are already enrolled. To receive the discounted rate, you must wait until your current plan ends.*

Books

Get health and wellness information to help you become a more educated consumer about your medical care. You can save on books, DVDs, CDs and more through:

- American Cancer Society Bookstore: Save on your purchase of books, greeting cards and kits.* Order online or by phone.
- Mayo Clinic Bookstore: Save on books and DVDs purchased online.
- Pranamaya: Save on yoga DVDs, CDs, online videos and books.

**Includes two or more books combined as a special discount package.*

Aetna Health Connections℠ Disease Management Program – For Medicare HMO members

Aetna's ongoing commitment to improve care for all members includes the Aetna Health Connections℠ Disease Management program which will deliver comprehensive support services for the significant number of people who present with one or more chronic or recurring conditions, or are at high risk of developing additional chronic conditions. While traditional disease management programs focus on delivering education to at-risk members about a specific chronic condition, the Aetna Health Connections℠ Disease Management program is based on a holistic, rather than condition-focused, view of each member. Aetna's Disease Management program addresses more than 30 chronic conditions, which often present as co-morbidities, in a holistic fashion.

Aetna's Disease Management program fully integrates powerful, innovative technology with the educational and outreach benefits of a disease management program and has a precise method for identifying appropriate candidates for disease management through the combination of predictive modeling and actionability assessments. Specifically, the patented ActiveHealth Management CareEngine will monitor all members with disease management benefits 100% of the time attempting to identify gaps, errors, omis-

sions or commissions. Regardless of their health status, Aetna's programs and web-based tools are designed to help members become more informed health consumers, more aware of their own health status, and more engaged in taking action to improve or maintain their health.

Member Health Education Programs

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, Aetna's innovative Member Health Education Programs offer health education, preventive care and wellness programs to Plan participants. These programs provide materials that, in conjunction with care and advice from a physician, help promote a healthy lifestyle and good health.

To obtain information on Member Health Education Programs, call the toll-free number on your ID card or visit ***www.aetna.com/products/health_education.html***

Adolescent Immunization

Adolescents need to see their doctors regularly for physical exams and screenings and to update immunizations. To reinforce the importance of protecting their children's health, parents of all 11- and 12-year-olds are sent a newsletter that includes examination and immunization schedule recommended for these age groups. This reminder is in the form of a newsletter provided by Merck & Co., Inc.

Preventive Reminders

Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats. Each year, Aetna sends a preventive health care reminder to households with a member who is particularly vulnerable to one or more of these diseases – adults who are age 50 and older, children ages 6-23 months, and people over age 2 with a chronic condition such as asthma, congestive heart failure, or chronic renal failure.

The reminder stresses the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screening.

Cancer Screening Programs

Early detection and treatment is important in helping our members lead longer, healthier lives. Member Health Education provides members with an important means of early detection.

Breast Cancer Screening

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease. The mailer may also include information on participating mammography centers or information for women who have chosen a primary care physician with a capitated radiology office.

Cervical

Gynecological examinations and Pap smears are vital to women's health because they are often the first step in the detection and treatment of abnormalities. This program reminds female members, starting at 18 years of age, to get exams and Pap smears on a regular basis. Annually, female members are sent information stressing the importance of annual gynecological exams, direct access to care, as well as instructions on how to perform breast self-examination.

Colorectal

The colorectal cancer cure rate can exceed 80 percent when detected early. We encourage you to discuss questions about colorectal cancer screening with your physician. Together you and your physician can choose the most appropriate method of colorectal cancer screening. Aetna sends annual reminders stressing the importance of completing appropriate colorectal cancer screening.

Childhood Immunization Program

Children need immunizations to protect them from a number of dangerous childhood diseases that could have very serious complications. Vaccines have been proven to be powerful tools for preventing certain diseases. It has been shown over time that the risks of serious illness from not vaccinating children far outweigh any risk of reaction to immunization. The common childhood diseases that vaccinations can guard against are:

- Measles
- Mumps
- Rubella
- Polio
- Pertussis (whooping cough)
- Diphtheria
- Tetanus
- Haemophilus influenzae type B
- Hepatitis B
- Varicella (chicken pox)

To promote good health through prevention, the Childhood Immunization Program sends immunization reminders to parents of children covered under this Plan.

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. This reminder contains a list of immunizations recommended at 18 months.*The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing immunizations.

If you have questions about specific vaccinations, please call your pediatrician or your family doctor.

**Source: Office of Prevention and Health Promotion, in cooperation with the agencies of Public Health Services, U.S. Department of Health and Human Services. Center for Disease Control and Prevention (CDC), American Association of Pediatrics (AAP), and Advisory Committee on Immunization Practices.*

Informed Health® Line

Informed Health® Line provides eligible Plan participants with telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses encourage informed health care decision making and optimal patient/provider relationships through information and support. However, the nurses do not diagnose, prescribe or give medical advice.

Informed Health Line is available to eligible employees and their families virtually 24-hours per day, 365 days per year from anywhere in the nation.

Backed by the Healthwise® Knowledgebase™ (a computerized database of over 1,900 of the most common health problems) and an array of other online and desk references, the nurses help you understand health issues, treatment options, review specific questions to ask your provider, provide research analyses of treatments and diagnostic procedures, and explain the risks and benefits of various options. The nurses encourage patient/provider interaction by coaching you to give a clear medical history and information to providers and to ask clarifying questions.

Transplant Expenses

Once it has been determined that you or one of your dependents may require an organ transplant, you, or your **physician** should call the Aetna precertification department to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements found in the Certification for Admissions sections of this document. Organ means solid organ, stem cell, bone marrow, and tissue.

Benefits may vary if an Institute of Excellence (IOE) facility or non IOE is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered out-of-network only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a preferred facility for other types of services, will not be covered. Please read each section carefully.

Covered Transplant Expenses

Covered transplant expenses include the following:

- 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 parent, sibling or child.
- Inpatient and outpatient expenses directly related to a transplant.
- 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 IOE 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.
- 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: (1) 180 days from the date of the transplant; or (2) 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 four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. **Pre-transplant Evaluation/Screening:** Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. **Pre-transplant/Candidacy Screening:** Includes human leukocyte antigen (HLA) typing/compatibility testing of prospective organ donors who are immediate family members.
3. **Transplant Event:** Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.
4. **Follow up Care:** Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/Lung
- Simultaneous Pancreas-Kidney (SPK)
- Kidney Liver Intestine
- Bone Marrow/Stem Cell transplant
- 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 Allogenic Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Allogenic 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).

Limitations

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 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 authorized by Aetna.

Women's Health Care

Aetna is focused on the unique health care needs of women. They have designed a variety of benefits and programs to promote good health throughout each distinct life stage, and are committed to educating female Plan participants about the lifelong benefits of preventive health care. Call 1-888-322-8742 to reach Aetna's Breast Health Education Center.

Support for Women with Breast Cancer

Aetna's Breast Health Education Center helps women make informed choices when they've been newly diagnosed with breast cancer. A dedicated breast cancer nurse consultant provides the following services:

- Breast cancer information,
- Second opinion options,
- Information about community resources,
- Benefit eligibility;

And help with accessing participating providers for:

- Wigs,
- Lymphedema pumps.

Confidential Genetic Testing for Breast and Ovarian Cancers

Aetna covers confidential genetic testing for Plan participants who have never had breast or ovarian cancer, but have a strong familial history of the disease. Screening test results are reported directly to the provider who ordered the test.

Direct Access for OB/GYN Visits

This program allows a female Plan participant to visit any participating gynecologist for one routine well-woman exam (including a Pap smear) per year, without a referral from her PCP. The Plan also covers additional visits for treatment of gynecological problems and follow-up care, without a PCP referral.

Participating general gynecologists may also refer a woman directly for appropriate gynecological services without the patient having to go back to her participating PCP.

If your gynecologist is affiliated with an IDS or provider group, such as an independent practice association (IPA), you may be required to coordinate your care through that IDS or provider group.

Infertility Case Management and Education

Aetna's Infertility Case Management program is a comprehensive education and information resource for women experiencing infertility.

Depending on the plan selected, the program may guide eligible members to a select network of infertility providers for services. If services are covered under the member's benefits plan, the Infertility Case Management unit will issue any necessary authorizations.

Aetna's Infertility Case Management unit is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility.

Beginning Right Maternity Program™

The Beginning Right™ maternity program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Educational materials on prenatal care, labor and delivery, postpartum depression and breastfeeding
- Specialized information for Dad or partner
- Web-based materials and access to program services through Women's Health Online
- Care coordination by trained obstetrical nurses
- Access to Smoke free Moms to be® smoking cessation program for pregnant women
- Preterm labor education
- Access to breastfeeding support services

Under the program, all care during your pregnancy is coordinated by your participating obstetrical care provider and program case managers, so there is no need to return to your PCP for referrals. However, your obstetrician will need to request a referral from Aetna for any tests performed outside of the office. To ensure that you are covered, please make sure your obstetrician has obtained this referral before the tests are performed.

Another important feature, **Pregnancy Risk Assessment,** identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

ELIGIBILITY

Active Employee Eligibility

Eligibility for coverage is determined by the State Health Benefits Program (SHBP) or the School Employees' Health Benefits Program (SEHBP). Enrollments, terminations, changes to coverage, etc. must be presented through your employer to either the SHBP or SEHBP. If you have any questions concerning eligibility provisions, you should contact the Division of Pensions and Benefits, Office of Client Services at (609) 292-7524 or ***pensions.nj@treas.nj.gov***

State Employees

To be eligible for State employee coverage, you must work full-time for the State of New Jersey or be an appointed or an elected officer of the State of New Jersey (this includes employees of a State agency or authority and employees of a State college or university). For State employees, full-time requires 35 hours per week or more if required by contract or resolution.

State Part-Time Employees

A part-time employee of the State — or a part time faculty member at an institution of higher education that participates in the SHBP — will be eligible for coverage under a SHBP medical plan and the Prescription Drug Plans if the employee is also enrolled in a State-administered retirement system. The employee must pay the full cost of the coverage. A part time employee will not qualify for employer or State-paid post-retirement health care benefits, but may enroll in the SHBP Retired Group at their own expense provided the employee was covered by the SHBP up to the date of retirement. See Fact Sheet #66, *Health Benefits Coverage for Part-Time Employees,* for details.

Local Employees

To be eligible for local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary from a local employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP or SEHBP. Each participating local employer defines the minimum hours required for full-time by a resolution filed with the Division of Pensions and Benefits, but it can be no less than 25 hours per week or more if required by contract or resolution. Employment must also be for 12 months per year, except for employees whose usual work schedule is 10 months per year (the standard school year).

Local Part-Time Employees

A part-time faculty member employed by a county college that participates in the SEHBP is eligible for coverage under a SEHBP medical plan — and if provided by the employer, the Prescription Drug Plans — if the faculty member is also enrolled in a State-administered retirement system. The faculty member must pay the full cost of the coverage. A part-time faculty member will not qualify for employer- or State-paid post-retirement health care benefits, but may enroll in the SEHBP Retired Group at their own expense provided the faculty member was continuously covered by the SEHBP up to the date of retirement. See Fact Sheet #66, *Health Benefits Coverage for Part-Time Employees,* for details.

Enrollment

You are not covered until you enroll in the SHBP or SEHBP. You must fill out a *Health Benefits Program Application* and provide all the information requested. If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so. Open Enrollment periods occur once a year usually during the month of October. Information about the dates of the Open Enrollment period and effective dates for coverage is announced by the Division of Pensions and Benefits.

Eligible Dependents

Your eligible dependents are your spouse, civil union partner, or eligible same-sex domestic partner and/or your eligible children (see definitions below). An eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent. Eligible children may only be covered by one participating subscriber.

Spouse — is a person to whom you are legally married. A photocopy of the *Marriage Certificate* and additional supporting documentation are required for enrollment.

Civil Union Partner — is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions,* for details).

Domestic Partner — is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP or SEHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey Certificate of Domestic Partnership dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

Children — In compliance with the federal Patient Protection and Affordable Care Act (ACA), coverage is extended for children until age 26. This includes natural children under age 26 regardless of the child's marital, student, or financial dependency status. A photocopy of the child's birth certificate that includes the covered parent's name is required for enrollment.

For a stepchild provide a photocopy of the child's birth certificate showing the spouse/partner's name as a parent **and** a photocopy of marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.

Foster children and children in a guardian-ward relationship under age 26 are also eligible. A photocopy of the child's birth certificate **and** additional supporting legal documentation are required with enrollment forms for these cases. Documents must attest to the legal guardianship by the covered employee.

Coverage for an enrolled child ends on December 31 of the year in which he or she turns age 26 (see the "COBRA" section, "Dependent Children with Disabilities" and "Over Age Children until Age 31" below for continuation of coverage provisions).

Dependent Children with Disabilities — If a child is not capable of self-support when he or she reaches age 26 due to mental illness, or a physical or mental disability, he or she may be eligible for a continuance of coverage.

To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions and Benefits, Health Benefits Bureau, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end.

Since coverage for children ends on December 31 of the year they turn 26, you have until January 31 to file the Continuance for Dependent with Disabilities form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP or SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

See Fact Sheet #51, *Continuing Health Benefits Coverage for Over Age Children with Disabilities,* for more information.

Over Age Children until Age 31 — Certain children over age 26 may be eligible for coverage until age 31 under the provisions of Chapter 375, P.L. 2005, as amended by Chapter 38, P.L. 2008. This includes a child by blood or law who: is under the age of 31; is unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

Under Chapter 375, an over age child does not have any choice in the selection of benefits but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. The covered parent or child is responsible for the entire cost of coverage. There is no provision for dental or vision benefits.

Coverage for an enrolled over age child will end when the child no longer meets any one of the eligibility requirements or if the required payment is not received. Coverage will also end when the covered parent's coverage ends. Coverage ends on the first of the month following the event that makes the dependent ineligible or up until the paid through date, in the case of non-payment.

See Fact Sheet #74, *Health Benefits Coverage of Children until Age 31 under Chapter 375,* for details.

Supporting Documentation Required for Enrollment of Dependents

The SHBP and SEHBP are required to ensure that only eligible employees, retirees, and their dependents are receiving health care coverage under the program. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation in addition to the enrollment application. See page 66 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

Audit of Dependent Coverage

The Division of Pensions and Benefits periodically performs audits using a random sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, or birth certificates, and tax returns are required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of ALL coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

Multiple Coverage under the SHBP/SEHBP is Prohibited

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

Medicare Coverage While Employed

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union partner, eligible same-sex domestic partner, or dependent child(ren) to be covered by Medicare while the employee remains actively at work. **However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD)** you and/or your dependents **must enroll** in Medicare Parts A and B even though you are actively at work. For more information, see "Medicare Coverage is Required" of the "Retiree Eligibility" Section.

Retiree Eligibility

The following individuals will be offered SHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time State employees, employees of State colleges/universities, autonomous State agencies and commissions, or local employees who were covered by, or eligible for, the SHBP at the time of retirement.
- Part-time State employees and part-time faculty at institutions of higher education that participate in the SHBP if enrolled in the SHBP at the time of retirement.
- Participants in the Alternate Benefit Program (ABP) eligible for the SHBP who retire with at least 25 years of credited ABP service or those who are on a long-term disability.
- Certain local policemen or firemen with 25 years or more of service credit in the pension fund, or retiring on a disability retirement, if the employer does not provide any payment or compensation toward the cost of the retiree's health benefits. A qualified retiree may enroll at the time of retirement or when he or she becomes eligible for Medicare. See Fact Sheet #47, *Retired Health Benefits Coverage under Chapter 330,* for more information.
- Surviving spouses, civil union partners, eligible same-sex domestic partners, and children of Police and Firemen's Retirement System (PFRS) members or State Police Retirement System (SPRS) members killed in the line of duty.

The following individuals will be offered SEHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time members of the Teachers' Pension and Annuity Fund (TPAF) and school board or county college employees enrolled in the Public Employees' Retirement System (PERS) who retire with less than 25 years of service credit from an employer that participates in the SEHBP.
- Full-time members of the TPAF and school board or county college employees enrolled in the PERS who retire with 25 years or more of service credit in one or more State- or locally-administered retirement systems, or who retire on a disability retirement, even if their employer did not cover its employees under the SEHBP. This includes those who elect to defer retirement with 25 or more years of service credit in one or more State or locally-administered retirement systems (see "Aggregate of Pension Membership Service Credit").
- Full-time members of the TPAF and PERS who: retire from a board of education, vocational/technical school, or special services commission; maintain participation in the health benefits plan of their former employer; and are eligible for and enrolled in Medicare Parts A and B.
- Participants in the Alternate Benefit Program (ABP) eligible for the SEHBP who retire with at least 25 years of credited ABP service or those who are on a long-term disability.
- Part-time faculty at institutions of higher education that participate in the SEHBP if enrolled in the SEHBP at the time of retirement.

Eligibility for SHBP or SEHBP membership for the individuals listed in this section is contingent upon meeting two conditions:

1. You must be immediately eligible for a retirement allowance from a State- or locally-administered retirement system (except certain employees retiring from a school board or community college); and
2. You were a full-time employee and eligible for employer-paid medical coverage immediately preceding the effective date of your retirement (if you are an employee retiring from a school board or community college under a deferred retirement with 25 or more years of service, you must have been eligible at the time you terminated your employment), or a part-time State employee or part-time faculty member who is enrolled in the SHBP or SEHBP immediately preceding the effective date of your retirement.

   This means that if you allow your active coverage to lapse (i.e. because of a leave of absence, reduction in hours, or termination of employment) prior to your retirement or you defer your retirement for any length of time after leaving employment; you will lose your eligibility for Retired Group health coverage. (This does not include full-time TPAF retirees and PERS board of education or county college retirees with 25 or more years of service).

   Note: *In this instance, if you continue group coverage through COBRA — or as a dependent under other group coverage through a public or private employer — until your retirement becomes effective, you will be eligible for retired coverage under the SHBP or SEHBP.*

   Otherwise qualified employees whose coverage is terminated prior to retirement **but who are later approved for a disability retirement** will be eligible for Retired Group coverage beginning on the employee's retirement date. If the approval of the disability retirement is delayed, coverage shall not be retroactive for more than one year.

Aggregate of Pension Membership Service Credit

Upon retirement, a full-time State employee, board of education, or county college employee who has 25 years or more of service credit, is eligible for State-paid health benefits under the SHBP or SEHBP. A full-time employee of a local government who has 25 years or more of service credit whose employer is enrolled in the SHBP **and** has chosen to provide post-retirement medical coverage to its retirees is eligible for employer-paid health benefits under the SHBP.

A retiree eligible for the SHBP or SEHBP may receive this benefit if the 25 years of service credit is from one or more State or locally-administered retirement systems and the time credited is nonconcurrent.

For PERS or TPAF members, Out-of-State Service, U.S. Government Service, or service with a bi-state or multi-state agency, requested for purchase after November 1, 2008, cannot be used to qualify for any State-paid or employer-paid health benefits in retirement.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage except for Chapter 334 domestic partners (described below) and the Medicare requirements.

Chapter 334, P.L. 2005, provides that retirees from local entities (municipalities, counties, boards of education, and county colleges) whose employers do not participate in the in SHBP or SEHBP, but who become eligible for SHBP or SEHBP coverage at retirement, may also enroll a registered same-sex domestic partner as a covered dependent provided that the former employer's plan includes domestic partner coverage for employees.

Multiple Coverage under the SHBP/SEHBP is Prohibited

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

Enrolling in Retired Group Coverage

The Health Benefits Bureau is notified when you file an application for retirement with the Division of Pensions and Benefits. If eligible, you will receive a letter inviting you to enroll in Retired Group coverage. Early filing for retirement is recommended to prevent any lapse of coverage or delay of eligibility.

If you do not submit a Retired Coverage Enrollment Application at the time of retirement, you will not generally be permitted to enroll for coverage at a later date. See Fact Sheet #11, *Enrolling for Health Benefits Coverage When You Retire,* for more information.

If you believe you are eligible for Retired Group coverage and do not receive an offering letter by the date of your retirement, please contact the Division of Pensions and Benefits, Office of Client Services at (609) 292-7524 or send an e mail to: ***pensions.nj@treas.nj.gov***

Additional restrictions and/or requirements may apply when enrolling in Retired Group coverage. Be sure to carefully read the "Retiree Enrollment" section of the *Summary Program Description* which is available on the Division of Pensions and Benefits Web site at: ***www.nj.gov/treasury/pensions/***

Medicare Coverage is Required if Eligible

IMPORTANT: A Retired Group member and/or dependent spouse, civil union partner, eligible same-sex domestic partner, or child who is eligible for Medicare coverage by reason of age or disability **must** be enrolled in both Medicare Part A (Hospital Insurance) **and** Part B (Medical Insurance) to enroll or remain in SHBP or SEHBP Retired Group coverage.

Medicare Parts A and B

You will be required to submit documented evidence of enrollment in Medicare Part A and Part B when you or your dependent becomes eligible for that coverage. Acceptable documentation includes a photocopy of the Medicare card showing both Part A and Part B enrollment, or a letter from Medicare indicating the effective dates of both Part A and Part B coverage.

Send your evidence of enrollment to the Health Benefits Bureau, Division of Pensions and Benefits, PO Box 299, Trenton, New Jersey 08625-0299 or fax it to (609) 341-3407. If you do not submit evidence of Medicare coverage under both Part A and Part B, you and/or your dependents will be terminated from coverage.

Upon submission of proof of full Medicare coverage, your Retired Group coverage will be reinstated by the Health Benefits Bureau on a prospective basis.

All members of the **Aetna Medicare Plan (HMO)** must be entitled to Medicare Part A and enrolled in and paying Part B premiums (and Part A premiums, if applicable). If at any time a member loses their Part B coverage, the Centers for Medicare and Medicaid Services (CMS) terminates the Aetna Medicare Plan (HMO) coverage.

IMPORTANT: If a provider does not participate with Medicare, no benefits are payable under the SHBP or SEHBP for the provider's services, the charges would not be considered under the medical plan, and the member will be responsible for the charges.

Medicare Part D

If you are enrolled in the Retired Group of the SHBP/SEHBP and eligible for Medicare, you will be automatically enrolled in the Express Scripts® Medicare Prescription Plan, a Medicare Part D plan.

Important: If you decide not to be enrolled in the Express Scripts® Medicare Prescription Plan, you will lose your *prescription drug* benefits provided by the SEHBP/SHBP. However, your medical benefits may continue. **Please note:** you cannot combine a standalone group Medicare Advantage Plan with an individual standalone prescription drug plan. To request that you not be enrolled, you must submit proof of enrollment in another Medicare Part D Plan.

Medicare Eligibility

A member may be eligible for Medicare for the following reasons:

Medicare Eligibility by Reason of Age

This applies to a member who is the retiree, a covered spouse, civil union partner, or eligible same-sex domestic partner and is at least 65 years of age. A member is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if he or she is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday. For members who are Medicare eligible and enrolled in the Aetna Medicare Plan (HMO), **the Aetna Medicare Plan (HMO) will be the primary insurance plan.**

Medicare Eligibility by Reason of Disability

This applies to a member who is under age 65. A member is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits for 24 months. For members who are Medicare-eligible and enrolled in the Aetna Medicare Plan (HMO), **the Aetna Medicare Plan (HMO) will be the primary insurance plan.**

Medicare Eligibility by Reasons of End Stage Renal Disease

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member who is not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD). When a person is eligible for Medicare due to ESRD, **Medicare is the secondary payer when:**

- The individual has group health coverage of their own or through a family member (including a spouse, civil union partner, or domestic partner).
- The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The rules described above, known as the Medicare Secondary Payer (MSP) rules, are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time. As of January 1, 2000, where the member becomes eligible for Medicare solely on the basis of ESRD, the Medicare eligibility can be segmented into three parts:

(1) An initial three-month waiting period;

(2) A "coordination of benefits" period; and

(3) A period where Medicare is primary.

Three-month Waiting Period

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, the group health plan is primary.

Coordination of Benefits Period

During the "coordination of benefits" period, **Medicare is secondary to the group health plan coverage.** Claims are processed first under the health plan. Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD after 1996, the coordination of benefits period is 30-months.

When Medicare is Primary

After the coordination of benefits period ends, **Medicare is considered the primary payer and the group health plan is secondary.** For any retiree who is enrolled in the Aetna Medicare Plan (HMO) (after becoming entitled to Medicare Part A and Part B), **the Aetna Medicare Plan (HMO) will be the primary insurance plan.** If you do not enroll in Medicare A and B before the end of the coordination of benefits period, your SHBP/SEHBP coverage will be terminated. It is your responsibility to file your application for Medicare so that the Medicare effective date is on or before the date that the coordination of benefits period ends.

Dual Medicare Eligibility

When the member is eligible for Medicare because of age or disability and then becomes eligible for Medicare because of ESRD:

- If the health plan is primary because the member has active employment status, then **the group health plan continues to be primary** to 30-months from the date of dual Medicare entitlement.
- If the health plan is secondary because the member is not actively employed, then **the health plan continues to be the secondary payer.** There is no 30-month coordination period. For any members enrolled in the Aetna Medicare Plan (HMO), regardless of whether they are Medicare-eligible due to age or disability, **the Aetna Medicare Plan (HMO) will be the primary insurance plan, not Medicare.**

How to File a Claim If You Are Eligible for Medicare

For all Aetna Medicare Plan (HMO) members, claims are submitted directly to Aetna, not to Medicare. Your provider will bill Aetna directly, using the claims address on the back of your Aetna Medicare Plan (HMO) ID card.

Members of the Aetna Medicare Plan (HMO) will receive one Explanation of Benefits from Aetna. Members do not need to coordinate with Medicare or submit any additional information. However, if a claim is submitted to Medicare in error, Medicare will deny the claim. In this case, the member can submit this claim information to Aetna (using the claims address on the back of the Aetna Medicare Plan (HMO) ID card) for processing under the Aetna Medicare Plan (HMO). Any questions can be directed to Aetna Medicare Plan (HMO) Member Services at 1-866-234-3129.

For all other Aetna members, follow the procedure listed below that applies to you when filing your claim.

New Jersey Physicians or Providers:

- You should provide the physician or provider with your identification number. This number is indicated on the Medicare Request for Payment (claim form) under "Other Health Insurance."
- The physician or provider will then submit the Medicare Request for Payment to the Medicare Part B carrier.
- After Medicare has taken action, you will receive an Explanation of Benefits statement from Medicare.
- If the remarks section of the Explanation of Benefits contains the following statement, you need not take any action: "This information has been forwarded to Aetna for their consideration in processing supplementary coverage benefits."

If the statement shown above does not appear on the Explanation of Benefits, please attach a completed Aetna claim form, to a copy of the itemized bill from your physician or provider along with a copy of the Medicare *Explanation of Benefits,* and submit it to Aetna using the address on the back of your ID card.

Out-Of-State Physicians or Providers:

- The Medicare Request for Payment form should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information.
- When you receive your Explanation of Benefits from Medicare please attach a completed Aetna claim form, attach a copy of the itemized bill from your physician or provider and submit it to Aetna using the address on the back of your ID card.

COBRA Coverage

Continuing Coverage When It Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods (see “Duration of COBRA Coverage”), and the member must pay the full cost of the coverage plus an administrative fee.

Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

Under COBRA, you may elect to enroll in any or all of the coverages you had as an active employee or dependent (health, prescription, dental, and vision), and you may change your health or dental plan when enrolling in COBRA. You may also elect to cover the same dependents that you covered while an active employee, or delete dependents from coverage — however, you cannot add dependents who were not covered while an employee except during the annual Open Enrollment period (see below) or unless a "qualifying event" (marriage, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

Open Enrollment — COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll, if eligible, in any medical, dental, or prescription drug coverage during the Annual Open Enrollment Period regardless of whether you elected to enroll for the coverage when you went into COBRA. This affords a COBRA enrollee the same opportunity to enroll for benefits during the Annual Open Enrollment Period as an active employee. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the State Health Benefits Commission or School Employees' Health Benefits Commission make changes to any benefit plan available to active employees and/or retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the member.
- Reduction in work hours.
- Leave of absence.
- Divorce, legal separation, dissolution of civil union or same-sex domestic partnership (makes spouse or partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through the attainment of age 26.
- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

Note: *Employees who at retirement are eligible to enroll for coverage in the Retired Group of the SHBP or SEHBP cannot enroll for health benefits coverage under COBRA.*

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Cost of COBRA Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Duration of COBRA Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of **termination of employment, a reduction in hours, or a leave of absence.**

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your **death, divorce, dissolution of a civil union or domestic partnership,** or a child becomes ineligible upon **attaining age 26,** or because you **elected Medicare as your primary coverage.**

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you, your spouse, civil union partner, or eligible same-sex domestic partner, and your children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred;
- Notify the Health Benefits Bureau of the Division of Pensions and Benefits within 30 days of the loss of an employee's coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and your dependents:

- Notify your employer (if you are retired, you must notify the Health Benefits Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, dissolution of a civil union or domestic partnership, or death has occurred, or that your child has reached age 26 — notification must be given within 60 days of the date the event occurred;
- File a *COBRA Application* within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a "qualified beneficiary" under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you.

Termination of COBRA Coverage

Your COBRA coverage will end when any of the following situations occur:

- Your eligibility period expires;
- You fail to pay your premiums in a timely manner;
- After the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- You voluntarily cancel your coverage;
- Your employer drops out of the SHBP or SEHBP;
- You become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

Special Plan Provisions of the Health Benefits Program

Automobile Related Injuries

The SHBP or SEHBP Plan will provide secondary coverage to Personal Injury Protection (PIP) unless you choose your Plan as your primary insurer on your automobile policy. In addition, if your automobile policy contains provisions that make PIP secondary or as excess coverage to your health plan, then the Plan will automatically be primary to your PIP policy. If you elect your Plan as primary, this election may affect each of your family members differently.

When the SHBP or SEHBP Plan is primary to your PIP policy, benefits are paid in accordance with the terms, conditions, and limits set forth by the Plan you have chosen. For example, if you are enrolled in an HMO you would need referrals from your Primary Care Physician, precertifications, preauthorizations, etc., just as you would for any other treatment to be covered. Your PIP policy would be a secondary payer to whom you would submit any bills unpaid by your Plan. Any portions of unpaid bills would be eligible for payment under the terms and conditions of your PIP policy.

Please note: *If you are covered by the retiree group and Medicare is primary for you and/or your spouse or eligible partner, you do not have the option to select the Plan as primary to your PIP policy.*

If your Plan is secondary to the PIP policy, the actual benefits payable will be the lesser of:

- The remaining uncovered allowable expenses after the PIP policy has provided coverage. The expenses will be subject to medical appropriateness and any other provisions of your Plan, after application of any deductibles and coinsurance; or
- The actual benefits that would have been payable had your Plan been primary to your PIP policy. If you are enrolled in several health plans, regardless of whether you have selected PIP as your

primary or secondary coverage, the plans will coordinate benefits as dictated by each plan's coordination of benefits terms and conditions. You should consult the coordination of benefits provisions in your various plans' handbooks and your PIP policy to assist you in making this decision.

Please note: *There is no coordination of benefits for prescription drug expenses.*

Work-Related Injury or Disease

Work-related injuries or disease are not covered under the SHBP or SEHBP. This includes the following:

- Injuries arising out of or in the course of work for wage or profit, whether or not you are covered by a Workers' Compensation policy.
- Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
- Work-related tests, examinations, or immunizations of any kind required by your work.

Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and the SHBP or SEHBP, you may be subject to prosecution for insurance fraud.

Health Insurance Portability and Accountability Act

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group health plans to implement several provisions contained within the law or notify its membership each plan year of any provisions from which they may file an exemption. Self-funded, non-federal government plans may elect certain exemptions from compliance with HIPAA provisions on a year-to-year basis.

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan.

Credit under this plan includes any prior group plan that was in effect 90 days prior to the individual's effective date under the new plan. A Certification of Coverage form, which verifies your group health plan enrollment and termination dates, is available through your payroll or human resources office, should you terminate your coverage.

HIPAA Privacy

The State Health Benefits Program and School Employees' Health Benefits Program make every effort to safeguard the health information of their members and comply with the privacy provisions of HIPAA, which requires that health plans maintain the privacy of any personal information relating to its members' physical or mental health.

Medical Plan Extension of Benefits

If you are disabled with a condition or illness at the time of your termination from the SHBP or SEHBP and you have no other group medical coverage, you may qualify for an extension of benefits for this specific condition or illness. If you feel that you may qualify for an extension of benefits please contact your claims administrator for assistance.

If the extension applies, it is only for expenses relating to the disabling condition or illness. An extension, under any Plan, will be for the time a member remains disabled from any such condition or illness, but not beyond the end of the calendar year after the one in which the person ceases to be a covered person. During an extension there will be no automatic restoration of part or all of a lifetime benefit maximum.

Termination for Cause

Your coverage and the coverage of your dependents under this Plan may be terminated for cause. "For cause" is defined as:

- **Untenable relationship:** After reasonable efforts, Aetna and/or the Plan's participating providers are unable to establish and maintain a satisfactory provider-patient relationship with the member, or the member repeatedly acts in a manner which is verbally or physically abusive.
- **Failure to make copayments:** The member fails to make required copayments or any other payment which he or she is required to pay.
- **Misuse of identification card:** The member permits any person to use his or her Aetna identification card.
- **Furnishing incorrect or incomplete information:** The member willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in or obtaining benefits from the Plan.
- **Non-compliance with your physician's plan of treatment:** You have the right to refuse any drugs, treatment or other procedure offered to you by a participating provider, and to be informed by your physician of the medical consequences of your refusal of any drugs, treatment or procedure. Aetna and your Primary Care Physician will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended plan of treatment, the Plan will not be responsible for the costs of further treatment for that condition, and you will be so notified. You may use the appeal process to have your case reviewed.
- **Misconduct:** The member abuses the system, including, but not limited to, theft, fraud, damage to the property of a participating provider or forgery of drug prescriptions.

No benefits, other than for emergency care, will be provided to you and your family members as of 31 days after the date notice of termination is given to you by Aetna. Any termination for cause is subject to review in accordance with the Plan's appeal process. If an appeal to Aetna is denied, you may appeal to the State Health Benefits Commission or School Employees' Health Benefits Commission. If the Commission governing your coverage upholds the termination, you must change your coverage by completing a *Health Benefits Program Application* to enroll in another health plan. Benefits under this Plan end when your application is received and processed by the Division of Pensions and Benefits, Health Benefits Bureau. If the Commission overrules the decision to terminate, full coverage will be restored retroactively.

Health Care Fraud

Health care fraud is an intentional deception or misrepresentation that results in an unauthorized benefit to a member or to some other person. Any individual who willfully and knowingly engages in an activity intended to defraud the SHBP or SEHBP will face disciplinary action that could include termination of employment and may result in prosecution. Any member who receives monies fraudulently from a health plan will be required to fully reimburse the plan.

MEMBER SERVICES

Member Services Department

Customer service professionals are trained to answer your questions and to assist you in using the plan properly and efficiently.

Call the Member Services toll-free number on your ID card to:

- Ask questions about benefits and coverage;
- Notify Aetna of changes in your name or telephone number;
- Change your Primary Care Physician (if applicable); or
- Notify Aetna about an emergency.

Please call your Primary Care Physician's office directly with questions about appointments, hours of service or medical matters.

Internet Access

You can access Aetna on the Internet at: ***www.aetna.com/members/member_services.html*** to conduct business with the Member Services department electronically.

When you visit the Member Services site, you can:

- Find answers to common questions;
- Change your Primary Care Physician (if applicable);
- Order a new ID card; or
- Contact the Member Services department with questions.

Please be sure to include your ID number, Social Security number and e mail address.

InteliHealth®

Aetna InteliHealth® is Aetna's online health information affiliate. It was established in 1996 and is one of the most complete consumer health information networks ever assembled. Through this unique program, Plan participants have access, via the Internet, to the wisdom and experience of some of the world's top medical professionals in the field today. Access InteliHealth through the Aetna Internet Web site home page or directly via: ***www.intelihealth.com***

Clinical Policy Bulletins

Aetna uses Clinical Policy Bulletins (CPBs) as a guide when making clinical determinations about health care coverage. CPBs are written on selected clinical issues, especially addressing new technologies, new treatment approaches, and procedures. The CPBs are posted on Aetna's Web site at: ***www.aetna.com***

Aetna Navigator®

Aetna Navigator® is your secure member Web site that provides health and benefits-related information. At the click of a mouse, you can access the site anywhere you have Internet access 24 hours a day, 7 days a week.

If you're enrolled in an Aetna plan and register to use Aetna Navigator®, you'll have access to personalized information on your claims and benefits eligibility. You also can request a replacement member ID card, contact Aetna Member Services and access the Healthwise Knowledgebase, a tool that can help you make more informed health care decisions.

Through Aetna Navigator®, you can link to Aetna InteliHealth®, Aetna's award-winning consumer health Web site, search DocFind®, Aetna's online provider directory.

For additional information, go to: ***www.aetna.com*** and take the Aetna Navigator® site tour. And if you're an Aetna member, be sure to register today!

COORDINATION OF BENEFITS

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this Plan when you or your covered dependents have health coverage under more than one plan. The Order of Benefit Determination Rules described below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of the total allowable expense.

Allowable Expense

Allowable Expense means a health care service or expense, including, coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in part by any of the plans covering the person. When a plan, such as an HMO, provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense.

The following are examples of expenses and services that are not **allowable expenses:**

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the plans provides coverage for a private room.
2. If a person is covered by 2 or more plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary plan because a covered person does not comply with the plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person for is not an allowable expense.

Plans that May Coordinate

Any plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

If the plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

In the following section this Plan is any part of the policy that provides benefits for health care expenses.

Which Plan Pays First (Aetna HMO members only)

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
2. **Child Covered Under More than One Plan.** The order of benefits when a child is covered by more than one plan is:

   A. The **primary plan** is the plan of the parent whose birthday is earlier in the year if:

   - The parents are married or living together whether or not married;
   - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsi-

ble for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the **primary plan.**

C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:

- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. **Active Employee or Retired or Laid off Employee.** The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the **primary plan.** The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the **secondary plan.** If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules listed above determine the order of benefits.

4. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules listed above determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, and subscriber longer is primary.

6. **If the preceding rules do not determine the primary plan,** the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, **This Plan will not pay more than it would have paid had it been primary.**

Note: *The rules listed above do not apply to the Aetna Medicare Plan (HMO). For anyone enrolled in the Aetna Medicare Plan (HMO), the Aetna plan will always be primary to another retirement plan, regardless of whether you are considered the subscriber or a dependent by the SHBP or SEHBP.*

How Coordination of Benefits Works

In determining the amount to be paid when this plan is secondary on a claim, the **secondary plan** will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of This Plan, the amount normally reimbursed for covered benefits or expenses under This Plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under This Plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. Such reduced amount will be charged against any applicable benefit limit of this coverage.

As a secondary plan, Aetna HMO2035 uses a non-duplication of benefits approach to COB. When Aetna HMO2035 is secondary to another health plan, Aetna HMO2035 will only provide reimbursement up to the normal liability if the plan had been primary. The secondary benefit payment under non-duplication COB is determined by calculating the Aetna HMO2035 normal liability then subtracting the other (primary) health plan payment and paying the remaining, if any. If the primary health benefit is the same as or higher than the Aetna HMO2035 benefit, no secondary payment will be made.

When the COB rules of **This Plan** and another plan both agree that **This Plan** determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule described above to the claim involved.

If a covered person is enrolled in two or more **closed panel plans** COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

If You Receive a Bill

Because you are a participant in an Aetna Plan, you do not need to submit a claim for most of your covered healthcare expenses. However, if you receive a bill for covered services, the bill must be submitted promptly to Aetna for payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card.

Aetna will make a decision on your claim. For **concurrent care** claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive written notice if Aetna makes an **adverse benefit determination.**

CLAIMS, APPEALS, AND EXTERNAL REVIEW

Filing Health Claims under the Plan

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims, Appeals, and External Review section includes you and your "Authorized Representative." An Authorized Representative is a person you authorize, in writing, to act on your behalf.

The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

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

Urgent Care Claims

An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the time periods for making non urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 24 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

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

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24-hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24-hours after receipt of the request.

Health Claims – Standard Appeals

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An “Adverse Benefit Determination” is defined as a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational;** or
- A decision that the service or supply is not **medically necessary.**

A “Final Internal Adverse Benefit Determination” is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan’s appeal requirements (“Deemed Exhaustion”) and may proceed with External Review.

Full and Fair Review of Claim Determinations and Appeals

Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this handbook, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on the back of your ID card (also listed at the end of this handbook). Your request should include the group name (that is, SHBP/SEHBP), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records, and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

External Review

"External Review" is a review of an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization (IRO).

A "Final External Review Decision" is a determination by an IRO at the conclusion of an External Review.

You must complete the two levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file an appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review* Form.

You must submit the *Request for External Review* Form to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file an appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan.

Request for External Review

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law; or
- The standard levels of appeal have been exhausted; or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review. An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna, and the Plan unless otherwise allowed by law.

Preliminary Review

Within five (5) business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review.

Within one (1) business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-EBSA). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization

Aetna will assign an Independent Review Organization (IRO) accredited as required under federal law, to conduct the External Review. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the IRO must consider when conducting the External Review. Within one (1) business day after making the decision, the IRO must notify you, Aetna, and the Plan.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- The terms of your Plan to ensure that the IRO 's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law;
- The opinion of the IRO 's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate;
- The extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO must provide written notice of the Final External Review Decision within 45 days after the IRO receives the request for the External Review. The IRO must deliver the notice of Final External Review Decision to you, Aetna, and the Plan.

After a Final External Review Decision, the IRO must maintain records of all claims and notices associated with the External Review process for six years. An IRO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan must allow you to request an expedited External Review at the time you receive:

Type of Claim	Level One Appeal: Response Time From Receipt of Appeal	Level Two Appeal: Response Time From Receipt of Appeal
Urgent Care Claim: a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	**36 hours** Review provided by Plan personnel not involved in making the adverse benefit determination.	**36 hours** Review provided by Plan personnel not involved in making the adverse benefit determination.
Pre-service claim: a claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	**15 calendar days** Review provided by Plan personnel not invloved in making the adverse benefit determination.	**15 calendar days** Review provided by Plan personnel not involved in making the adverse benefit determination.
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Treated like an urgent care claim or pre-service claim, depending on the circumstances.	Treated like an urgent care claim or pre-service claim, depending on the circumstances.
Post-service claim: a claim for a benefit that is not a pre-service claim.	**30 calendar days** Review provided by Plan personnel not involved in making the adverse benefit determination.	**30 calendar days** Review provided by Plan personnel not involved in makin the adverse benefit determination.

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to External Review Organization

Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an IRO.

The IRO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you, Aetna, and the Plan.

Benefit Appeal Time Frames

Administrative Appeals

Appeals for SHBP/SEHBP members that question an adverse determination involving benefit limits, exclusions or contractual issues are considered Administrative Appeals. Appeals must be submitted within one year following your receipt of the initial adverse benefit determination. Administrative appeals might also question enrollment, eligibility, or plan benefit decisions such as whether a particular service is covered or paid appropriately.

Examples of Administrative Appeals are:

- Visits beyond the 20-visit Chiropractic Limit
- Benefits for a Wig that exceed the $500/24-month limit
- Hearing Aid for a 60 year old member

The member or member's legal representative must appeal in writing to the Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf.

Request for Commission consideration must contain the reason, in detail, for the disagreement along with copies of all relevant correspondence and should be directed to:

Appeals Coordinator
State Health Benefits Commission or
School Employees' Health Benefits Commission
P.O. Box 299
Trenton, NJ 08625 0299

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps (s)he may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request, within 45 days, in writing to the Commission that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so, the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify or reject. If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals will be made to the Superior Court of New Jersey Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. You will be responsible for any court filing fees or related costs that may be necessary during the appeal process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

SUBROGATION AND RIGHT OF RECOVERY PROVISION

Definitions

As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

Subrogation

Immediately upon paying or providing any benefit under this Plan, and in a jurisdiction that permits subrogation, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the Plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed 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, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

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 by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person 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.

Cooperation

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her 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. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person 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.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The Plan reserves the right to notify the Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

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 (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees 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, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

YOUR RIGHTS AND RESPONSIBILITIES

As a Plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan.
- Obtain primary and preventive care from the Primary Care Physician you chose from the Plan's network.
- Change your Primary Care Physician (if applicable) to another available Primary Care Physician who participates in the Aetna network.
- Obtain covered care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your Primary Care Physician or a back up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit the customized Web site at: ***www.aetna.com/docfind/custom/statenj***
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered and any applicable limitations or exclusions.
- Get information about copayments and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

As a Plan participant, you have the responsibility to:

- Choose a Primary Care Physician from the Plan's network and form an ongoing patient-doctor relationship. (Applies to Aetna HMO members only.) Members of the Aetna Medicare Plan (HMO) are not required, but strongly encouraged, to select a Primary Care Physician.

- Help your doctor make decisions about your health care.
- Tell your Primary Care Physician if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Consult with your Primary Care Physician for non-emergency referrals to specialist or hospital care.
- See the specialists your Primary Care Physician refers you to.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Call your Primary Care Physician before getting care at an emergency facility, unless a delay would be detrimental to your health. (Applies to Aetna HMO members only.)
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your ID card to providers before getting care from them.
- Pay the copayments required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments and what services are covered and what services are not covered.

Patient Self Determination Act (Advance Directives)

There may be occasions when you are not able to make decisions about your medical care. An Advance Directive can help you and your family members in such a situation.

What Is an Advance Directive?

An Advance Directive is generally a written statement that you complete in advance of serious illness that outlines how you want medical decisions made.

If you can't make treatment decisions, your physician will ask your closest available relative or friend to help you decide what is best for you. But there are times when everyone doesn't agree about what to do. That's why it is helpful if you specify in advance what you want to happen if you can't speak for yourself. There are several kinds of Advance Directives that you can use to say **what** you want and **whom** you want to speak for you. The two most common forms of an Advance Directive are:

- A Living Will; and
- A Durable Power of Attorney for Health Care.

What Is a Living Will?

A Living Will states the kind of medical care you want, **or do not want,** if you become unable to make your own decisions. It is called a Living Will because it takes effect while you are still living.

The Living Will is a document that is limited to the withholding or withdrawal of life-sustaining procedures and/or treatment in the event of a terminal condition. If you write a living will, give a copy to your Primary Care Physician.

What Is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a document giving authority to make medical decisions regarding your health care to a person that you choose. The Durable Power of Attorney is planned to take effect when you can no longer make your own medical decisions.

A Durable Power of Attorney can be specific to a particular treatment or medical condition, or it can be very broad. If you write a Durable Power of Attorney for Health Care, give a copy to your Primary Care Physician.

Who Decides About My Treatment?

Your physicians will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment you don't want — even if the treatment might keep you alive longer.

How Do I Know What I Want?

Your physician must tell you about your medical condition and about what different treatments can do for you. Many treatments have side effects, and your doctor must offer you information about serious problems that medical treatment is likely to cause you. Often, more than one treatment might help you — and people have different ideas about which is best. Your physician can tell you which treatments are available to you, but they can't choose for you. That choice depends on what is important to you.

How Does the Person Named in My Advance Directive Know What I Would Want?

Make sure that the person you name knows that you have an Advance Directive and knows where it is located. You might consider the following:

- If you have a Durable Power of Attorney, give a copy of the original to your "agent" or "proxy." Your agent or proxy is the person you choose to make your medical decisions when you are no longer able.
- Ask your Primary Care Physician to make your Advance Directive part of your permanent medical record.
- Keep a second copy of your Advance Directive in a safe place where it can be found easily, if it is needed.
- Keep a small card in your purse or wallet that states that you have an Advance Directive and where it is located, and who your agent or proxy is, if you have named one.

Who Can Fill Out the Living Will or Advance Directive Form?

If you are 18 years or older and of sound mind, you can fill out this form. You do not need a lawyer to fill it out.

Whom Can I Name to Make Medical Treatment Decisions When I'm Unable to Do So?

You can choose an adult relative or friend you trust to be your agent or proxy, and to speak for you when you're too sick to make your own decisions.

There are a variety of living will forms available, or you can write your wishes on a piece of paper. If necessary, your doctor and family can use what you write to help make decisions about your treatment.

Do I Have to Execute an Advance Directive?

No. It is entirely up to you.

Will I Be Treated If I Don't Execute an Advance Directive?

Absolutely. We just want you to know that if you become too ill to make decisions, someone else will have to make them for you. With an Advance Directive, you can instruct others about your wishes before becoming unable to do so.

Can I Change My Mind After Writing an Advance Directive?

Yes. You may change your mind or cancel these documents at any time as long as you are competent and can communicate your wishes to your physician, your family and others who may need to know.

What Is the Plan's Policy Regarding Advance Directives?

We share your interest in preventive care and maintaining good health. Eventually, however, every family may face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important in the future and urge you to discuss these topics with your Primary Care Physician, family, friends, and other trusted, interested people. You are not required to execute an Advance Directive. **If you choose to complete an Advance Directive, it is your responsibility to provide a copy to your physician and to take a copy with you when you check into a hospital or other health facility so that it can be kept with your medical records.**

How Can I Get More Information About Advance Directives?

Call the Member Services toll-free number on your ID card. Or, you can call Partnership for Caring at Choice in Dying, a community organization, at 1-800-989-9455.

FEDERAL NOTICES

This section describes laws and plan provisions that apply to reproductive and women's health issues.

The Newborns' and Mothers' Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay to less than 48 hours following a vaginal delivery and less than 96 hours following a caesarean section. However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that plan benefits may not, for the purpose of benefits or out of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

The Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, this Plan covers the following procedures for a person receiving benefits for an **appropriate** mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

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

For answers to questions about the plan's coverage of mastectomies and reconstructive surgery, call Aetna's Member Services at the number shown on your ID card.

Plan Information

Amendment or Termination of the Plan

The State of New Jersey has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified.

The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any nonforfeitable right to continued participation in any benefits plan.

Plan Documents

This plan description covers the major features of the Plans administered by Aetna Life Insurance Company. The plan description has been designed to provide a clear and understandable summary of the Plan.

Provider Termination

When we know a Primary Care Physician (PCP) is leaving our network, we make a good faith effort to notify affected members by mail within 30 days. Our letter advises the member to choose a new PCP. If needed, we will assist members in selecting a new PCP. To select a new PCP, members can call the toll-free member services number on their ID card or visit Aetna Navigator®, our online member and consumer resource center at: ***www.aetna.com***

Required Documentation for Dependent Eligibility and Enrollment

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and their eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation in addition to the appropriate health benefits application.

Specific required documents are detailed in the chart on page 66.

New Jersey residents can obtain records from the State Bureau of Vital Statistics and Registration Web site: ***www.state.nj.us/health/vital/index.shtml*** To obtain copies of other documents listed on this chart, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these Web sites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org***

Required Documentation for Dependent Eligibility and Enrollment

Dependent	Eligibility Definition	Required Documentation
Spouse	A person to whom you are legally married.	A photocopy of the Marriage Certificate **and** a photocopy of the front of the employee/retiree's most recently filed tax return* *(Form 1040)* that includes the spouse. If filing separately, submit a copy of both spouses' tax returns.
Civil Union Partner	A person of the same sex with whom you have entered into a civil union.	A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the front page of the employee/retiree's most recently filed NJ tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
Domestic Partner	A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or any eligible employee or retiree of a SHBP/SEHBP participating local public entity, who adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage.	A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19,2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the front page of the employee/retiree's most recently filed NJ tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.

Continued on next page

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.*

Required Documentation for Dependent Eligibility and Enrollment

Dependent	Eligibility Definition	Required Documentation
Children	A subscriber's child until age 26. regardless of the child's marital, student or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child –** A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent.** **Step Child –** Natural or Adopted Child – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child –** Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.
Dependent Children with Disabilities	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. See "Dependent Children with Disabilities" on page 33 for additional information. You will be contacted periodically to verify that the child remains eligible for continued coverage.	Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* *(Form 1040)* that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. **Please note** that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
Continued Coverage for Over Age Children	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. See "Over age Children until Age 31" for additional information.	Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* *(Form 1040)* and if the child resides outside of the State of New Jersey, documentation of a full time student.

**Note: On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.*

*** Or a National Medical Support Notice (NMSN) if you are the non custodial parent and are legally required to provide coverage for the child as a result of the NMSN.*

GLOSSARY

Appeal – A request made by a member, doctor, or facility that a carrier review a decision concerning a claim. Administrative appeals question, plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of need or appropriateness of treatment or whether treatment is considered experimental or educational in nature. Appeals to the State Health Benefits Commission or School Employees' Health Benefits Commission may only be filed by a member or the member's legal representative.

Chronic Condition –A disease or ailment of long duration or frequent recurrence. When a condition is neither regressing nor improving, or maximum therapeutic benefit has been achieved, or substantial further improvement is unlikely in the short term, then it is considered chronic in nature. Therapy for a chronic condition may be excluded from coverage (see also "Maintenance Care").

Civil Union Partner – Civil Union Partner — A person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey Civil Union Certificate or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, Civil Unions, for details).

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law requires private employers with more than 20 employees and all public employers to allow covered employees and their dependents to remain on group insurance plans for limited time periods at their own expense under certain conditions.

Coinsurance – The sharing of certain covered expenses by the Plan and the Plan participant. For example, if the Plan covers an expense at 80 percent (the Plan's coinsurance), your coinsurance share is 20 percent

Companion – A person whose presence as a companion or caregiver is necessary to enable a National Medical Excellence (NME) patient to:

- Receive services from an NME Program provider on an inpatient or outpatient basis; or
- Travel to and from an NME Program provider to receive covered services.

Coordination of Benefits – The practice of correlating the payments a plan makes with payments provided by other insurance covering the same charges or expenses, so that (1) the plan with primary responsibility pays first, (2) reimbursement does not exceed 100 percent of the allowable expense, and (3) the plan does not pay more than it would if no other insurance existed.

Copayment – The fee that must be paid by a Plan participant to a participating provider at the time of service for certain covered expenses and benefits, as described in the "Copayment Schedule."

Cosmetic Surgery – Any surgery or procedure that is not medically necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not:

- Restore bodily function;
- Correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or
- Correct or naturally improve a physiological function.

Covered Services and Supplies (covered expenses) – The types of medically necessary services and supplies described in "Your Benefits."

Custodial Care – Services that do not require the skill level of a nurse to perform. These services include but are not limited to assisting with activities of daily living, meal preparation, ambulation, cleaning, and laundry functions. Custodial care services are not eligible for coverage, including those that are considered to be medically needed.

Deductible – The amount of covered, self-referred expenses that a Plan participant must pay each calendar year before the Plan begins paying benefits.

Detoxification – The process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.

Domestic Partner – A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the New Jersey Certificate of Domestic Partnership dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, Benefits Under the Domestic Partnership Act, for details).

Durable Medical Equipment (DME) – Equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Emergency – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or a guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

- Serious impairment to bodily function.
- Serious dysfunction of bodily organ or part.

Claims will be paid for emergency services furnished in a hospital emergency department if the presenting symptoms reasonably suggested an emergency condition as would be interpreted by a prudent layperson. All procedures performed during the evaluation (triage) and treatment of an emergency condition will be covered.

Employer – The State or a local public employer which participates in the State Health Benefits Program, or a local educational employer which participates in the School Employees' Health Benefits Program.

Experimental or Investigational – Services or supplies that are determined by Aetna to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol(s) used by the treating facility or the protocol(s) 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 for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes.

Home Health Services – Items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by Aetna.

Hospice Care – A program of care that is:

- Provided by a hospital, skilled nursing facility, hospice or duly licensed hospice care agency;
- Approved by Aetna; and
- Focused on palliative rather than curative treatment for a Plan participant who has a medical condition and a prognosis of less than 6 months to live.

Hospital – An approved institution that meets the tests of (1), (2), (3), (4), or (5) listed below:

1. It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals and Medicare approved.
2. It (a) is legally operated, (b) is supervised by a staff of doctors, (c) has 24-hour-a-day nursing service by registered graduate nurses, and (d) mainly provides general inpatient medical care and treatment of sick and injured persons by the use of the medical, diagnostic, and major surgical facilities in it.
3. It is licensed as an ambulatory or separate surgical center. The center must mainly provide out-patient surgical care and treatment.
4. It is an institution for the treatment of alcoholism not meeting all the tests of (1) or (2) but which is:
    - A licensed hospital; or
    - A licensed detoxification facility; or
    - A residential treatment facility which is approved by a state under a program that meets standards of care equivalent to those of the Joint Commission on Accreditation of Hospitals.

5. It is a birth center that is licensed, certified, or approved by a department of health or other regulatory authority in the state where it operates or meets all of the following tests:
    - It is equipped and operated mainly to provide an alternative method of childbirth;
    - It is under the direction of a doctor;
    - It allows only doctors to perform surgery;
    - It requires an exam by an obstetrician at least once before delivery;
    - It offers prenatal and postpartum care.
    - It has at least two birthing rooms;
    - It has the necessary equipment and trained people to handle foreseeable emergencies. The equipment must include a fetal monitor, incubator, and resuscitator;
    - It has the services of registered graduate nurses;
    - It does not allow patients to stay more than 24 hours;
    - It has written agreements with one or more hospitals in the area that meet the tests in (1) or (2) listed above and will immediately accept patients who develop complications or require post-delivery confinement;
    - It provides for periodic review by an outside agency; and
    - It maintains proper medical records for each patient.

"Hospital" does not include a nursing home. Neither does it include an institution, or part of one, that:

- Is used mainly as a place for convalescence, rest, nursing care, or for the aged or drug addicts.
- Is used mainly as a center for the treatment and education of children with mental disorders or learning disabilities.
- Provides home-like or custodial care.

Infertility – Means you are not able to:

- Impregnate another person;
- Conceive after two years if the female partner is under 35 years old, or after one year if the female partner is 35 years old or older, or if one partner is considered medically sterile; or
- Carry a pregnancy to live birth.

Local Employee – For purposes of health benefits coverage, a local employee is a full-time employee receiving a salary and working for a Participating Local Employer. Full-time shall mean employment of an eligible employee who appears on a regular payroll and who receives salary or wages for an average number of hours specified by the employer, but not to be less than 20 hours per week. It also means employment in all 12 months of the year except in the case of those employees engaged in activities where the normal work schedule is 10 months. In addition, for local coverage, employee shall also mean an appointed or elected officer of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary but who is not a self-employed independent contractor compensated in a like manner. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by law, ordinance, resolution, or such other official action required by law for establishment of a public office by an appointing authority. A person appointed under

a general authorization, such as to appoint officers or to appoint such other officers or similar language is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation as a full-time employee.

Local Employer – Government employers in New Jersey, including counties, municipalities, townships, school districts, community colleges, and various public agencies or organizations.

Maintenance Care – Care that when provided does not substantially improve the condition. When care is provided for a condition that has reached maximum improvement and further services will not appreciably improve the condition, care will be deemed to be maintenance care and no longer eligible.

Medical Services – Professional services of physicians or other health professionals, including medical, surgical, diagnostic, therapeutic and preventive services authorized by Aetna.

Medically Necessary – Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the "Your Benefits" section of this member handbook. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the tests listed above.

In determining whether a service or supply is medically necessary, Aetna will consider:

- Information provided on your health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to Aetna's attention.

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

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting; or
- Experimental services and supplies, as determined by Aetna.

Medicare – The federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medical coverage consists of three parts: Part A is Hospital Insurance Benefits, Part B is Medical Insurance Benefits, and Part D is Prescription Drug Benefits. A retired group member and/or spouse, civil union partner, or eligible same-sex domestic partner who is eligible for Medicare coverage by reason of age or disability must be enrolled in Parts A and B to enroll or remain in Retired Group coverage.

Member – An employee or covered dependent enrolled in an Aetna plan.

Mental or Nervous Condition – A condition which manifests signs and/or symptoms that are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited to:

- Psychosis;
- Affective disorders;
- Anxiety disorders;
- Personality disorders;
- Obsessive-compulsive disorders;
- Attention disorders with or without hyperactivity; and
- Other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

NME Patient – A person who:

- Requires any National Medical Excellence procedure or treatment covered by the Plan;
- Is approved by Aetna as an NME patient; and
- Agrees to have the procedure or treatment performed in a facility designated by Aetna as the most appropriate facility.

Outpatient – This is:

- A Plan participant who is registered at a practitioner's office or recognized health care facility, but not as an inpatient; or
- Services and supplies provided in such a setting.

Partial Hospitalization – Medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be provided in a hospital or non-hospital facility that is licensed as an alcohol, drug abuse or mental illness treatment program by the appropriate regulatory authority.

Participating Provider – A provider that has entered into a contractual agreement with Aetna to provide services to Plan participants.

Physician – A duly licensed member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where they practice, and who provides medical services which are within the scope of their license or certificate.

Plan Benefits – Medical services, hospital services, and other services and care to which a Plan participant is entitled, as described in this member handbook.

Plan Participant – A member enrolled in an Aetna plan.

Primary Care Physician – A participating physician who supervises, coordinates, and provides initial care and basic medical services as a general or family care practitioner or, in some cases, as an internist or a pediatrician, to Plan participants; initiates their referral for specialist care; and maintains continuity of patient care.

Provider – The term is used to define an eligible provider and includes medical doctors, dentists, podiatrists, acupuncturists, psychologists, psychiatrists, nurse midwives, licensed clinical social workers, chiropractors, certified nurse practitioners, clinical nurse specialists, physical therapists, occupational therapists, optometrists, audiometrists, licensed marriage and family therapists and licensed professional counselors who are properly licensed and are working within the scope of their practice.

Public Facility – A facility, including a non-participating Hospital, a school or other institution owned or operated by any federal, state or other governmental entity.

Referral – Specific written or electronic direction or instruction from a Plan participant's primary care physician, in conformance with Aetna's policies and procedures, which directs the Plan participant to a participating provider for medically necessary care.

Respite Care – Care provided during a period of time when the insured's usual caregiver is not attending to the insured.

School Employees' Health Benefits Commission – The entity created by N.J.S.A. 52:14-17.46 and charged with the responsibility of overseeing the School Employee's Health Benefits Program.

School Employees' Health Benefits Program (SEHBP) – The SEHBP was established by Chapter 103, P.L. 2007. It offers medical and prescription drug coverage to qualified school employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SEHBP. The School Employees' Health Benefits Program Act is found in the N.J.S.A. 52:14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

SEHBP Member – An individual who is either a School Employees' Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

Service Area – The geographic area, established by Aetna and approved by the appropriate regulatory authority, in which a Plan participant must live or work or otherwise meet the eligibility requirements in order to be eligible as a participant in the Plan.

SHBP Member – An individual who is either a State Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

Skilled Nursing Facility – An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist – A physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Specialty Pharmacy Network – A network of pharmacies designated to fill self-injectable drug prescriptions.

Spouse – A person to whom you are legally married. A photocopy of the Marriage Certificate and additional supporting documentation are required for enrollment.

State Health Benefits Commission (Commission) – The entity created by N.J.S.A. 52:14-17.27 and charged with the responsibility of overseeing the State Health Benefits Program.

State Health Benefits Program (SHBP) – The SHBP was established in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP. The State Health Benefits Program Act is found in the N.J.S.A. 52:14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

State Monthly Employer – Employers whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). This includes state colleges and universities and participating independent state commissions, authorities, and agencies such as:

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- Thomas Edison State University
- William Paterson University
- Ramapo State College
- Rowan University
- The College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University

- Stockton University
- New Jersey State Library
- New Jersey State legislature and legislative offices
- New Jersey Building Authority
- New Jersey Commerce and Economic Growth Commission
- Waterfront Commission of New York Harbor
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program.

Substance Abuse – Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Supportive Care – Care for patients having reached the maximum therapeutic benefit in which periodic trials of therapeutic withdrawals failed to sustain previous therapeutic gains. Supportive care services, even those that are considered to be medically needed, are not eligible for coverage.

Terminal Illness – An illness of a Plan participant, which has been diagnosed by a physician and for which they have a prognosis of six (6) months or less to live.

Urgent Medical Condition – A medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your Primary Care Physician.

Waiting Period – The period of time between enrollment in the State Health Benefits Program or School Employees' Health Benefits Program and the date when you become eligible for benefits.