State of New Jersey

AETNA MEMBER HANDBOOK

Aetna Value HD Plan

Aetna Freedom Plan

Aetna Medicare Advantage PPO ESA 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 Aetna Value HD and Aetna Freedom plan options are self-funded by the State of New Jersey 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 website at ***www.nj.gov/treasury/pensions/health-benefits.shtml***

Be sure to check the website 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 website 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. 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 Value HD and Aetna Freedom plans (referred to collectively in this handbook as the Plan). Please read the handbook carefully and refer to it when you need information about how the Plan works, what the Plan covers and how this Plan coordinates with other coverages you may have. 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 shown on your ID card. A trained representative will be happy to help you.

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.

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AETNA VALUE HD PLANS: OVERVIEW

The Aetna Value HD plans combine a point-of-service medical plan with a tax-favored health savings account that you can use to pay for qualified medical expenses. The funds in your HSA can pay for qualified medical expenses now (including the medical plan's deductible) or accumulate over time to pay for future expenses.

There are two Aetna Value HD options:

- Aetna Value HD 1500
- Aetna Value HD 4000*

  ** Local education active employees are not eligible for the Aetna Value HD 4000 plan.*

The Health Savings Account

You may be eligible to open a health savings account (HSA) when you enroll in an Aetna Value HD plan. The HSA is an interest-bearing account that works with the high deductible health plan to give you greater control over how you manage your health care spending.

Eligibility and Enrollment

To be eligible to open an HSA, you must be enrolled in an Aetna Value HD plan. You cannot open an HSA if:

- You are enrolled in or eligible for Medicare;
- You are covered by any other health care plan, including a Health Reimbursement Account or Flexible Spending Account; or
- You can be claimed as a dependent on someone else's federal tax return.

Funding Your Account

Your account is funded by pre-tax contributions you make through regular payroll deductions. The 2016 annual maximum for all contributions to your account is:

- $3,350 if you elect coverage for yourself only; or
- $6,750 if you elect family coverage ("employee and spouse," "employee and child" or "employee and family").

The maximums are determined by the U.S. Treasury Department and subject to future cost-of-living adjustments.

If your payroll contributions are less than the annual maximum, you may choose to make up the difference at any point during the year by electronic fund transfer or by mailing a personal check to the address on the HSA deposit slip.

If you are age 55 or older, you may make an additional "catch-up" contribution of $1,000 per year. Catch-up contributions can be made via an electronic funds transfer (EFT) or by check; they cannot be payroll-deducted.

If you have questions about how to make a catch-up contribution, contact Aetna Member Services at **1-877-782-8365.**

Using the Funds in Your Account

Qualified Expenses

You can use your HSA to pay for qualified health care expenses, as defined by the Internal Revenue Service (IRS). Qualified medical expenses include your medical plan deductible and coinsurance payments. You can also use the HSA to pay for other qualified health-related care such as out-of-pocket dental and vision expenses. A complete list of HSA-qualified expenses can be found at ***www.irs.gov*** click on Forms and Publications, then select IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans, and IRS Publication 502, *Medical and Dental Expenses.*

Consult your tax advisor if you have questions about qualified expenses.

Payment Options

When you have qualified expenses, you have a choice to make:

- You can pay the expenses out of pocket and save your HSA funds for future qualified health expenses; or
- You can pay for the expenses using your HSA funds.

You will receive an HSA debit card in your HSA Welcome Kit when you first open your HSA. You can use your debit card to pay for qualified expenses from your HSA funds.

If you do not have your debit card with you when paying for qualified expenses and have to pay out of pocket, you can pay your provider online, right from your computer.

Save receipts from all transactions associated with HSA contributions and withdrawals for your tax records.

AutoDebit

The AutoDebit feature allows you to have out-of-pocket medical expenses automatically withdrawn from your HSA to pay for your share of medical claims. AutoDebit is a convenient way to pay your share of medical care from HSA funds without using your HSA debit card or HSA checks.

Here's how it works:

- You receive medical care from a physician or other health care provider.
- You or the provider submits a claim to Aetna.
- Aetna determines the appropriate amount of reimbursement for the doctor, as well as your share of the cost, based on the HDHP.
- Aetna withdraws funds directly from your HSA for qualified out-of-pocket expenses, up to your available balance.
- Aetna pays the provider using those funds.

Your doctor will bill you for any portion of your share of the cost that couldn't be paid from your HSA balance.

You can elect the AutoDebit feature after you open your HSA. Log in to your member website at ***www.aetnastatenj.com*** or call Aetna Member Services and ask for the AutoDebit enrollment form.

> You should not elect the AutoDebit option if you want to use your HSA to save for future medical expenses.

Save for Future Health Care Expenses

Your account can grow. Unused funds earn tax-free interest, with no minimum balance requirement. If you have money left in your account at the end of the year, it is rolled over to the following year and continues to accrue interest. Once your HSA accumulates $2,000, you may be able to take advantage of HSA investment services.

If You Change Plans or Leave Your Employer

You own your HSA — if you change plans or terminate employment with the State of New Jersey, you don't lose the money in your account. You can:

- Leave the money in your current account. You won't be able to make future contributions, but you can still use the funds to pay for qualified expenses or save them for future needs. A monthly account maintenance fee will be deducted automatically from your HSA balance.
- Transfer the balance in your account to another HSA trustee or custodian.
- Close the account and receive the remaining balance.

If you roll the balance into a new HSA within 60 days, there are no tax implications.

Taxes and penalties may apply if you do not roll the funds to another HSA within the 60-day window.

Tax Advantages

Not only can you save money for the future, your HSA can help you save money on your taxes now!

- Contributions you make to your HSA through payroll deduction are made with pre-tax dollars. That lowers your taxable income, so you pay lower federal income taxes and Social Security taxes.
- If you make contributions to your HSA with a personal check, your contributions are tax-deductible because you are using after tax dollars (money that has already been subject to income tax). You can take this tax credit above the line for post tax contributions on your tax preparation form.
- The money you withdraw from your HSA to pay for qualified expenses is not subject to federal income tax.
- The interest earned on your HSA funds is not subject to federal income tax.

Consult your tax advisor if you have questions about the tax implications of HSA contributions.

Helpful Tools

Aetna provides online resources to help you use your HSA and make decisions about health care. You can track your HSA activity online, 24/7, by logging in to your Aetna Navigator member website at ***www.aetnastatenj.com*** For more information about Aetna Navigator, see When You Need Help.

You can also call Aetna Member Services at 1-877-782-8365 if you have any questions about your Aetna HSA.

Summary of Benefits: Aetna Value HD Plans

Keep in mind:

- The Plan pays benefits only for care that is **necessary.**
- The **deductible** is the part of your covered expenses you pay before the Plan starts to pay benefits each year.
- The Plan's **coinsurance** is the percentage of covered expenses that the Plan pays after you satisfy the Plan's calendar year deductible. The **coinsurance limit** is the maximum you pay as your coinsurance share each year.
- The **out-of-pocket maximum** is the limit on the amount you pay for covered medical expenses out of your own pocket each year. It includes your medical plan deductible and your coinsurance.
- **Network providers** have agreed to charge no more than the **negotiated charge** for a service or supply that is covered by the Plan. You are not responsible for amounts that exceed the negotiated charge when you get care from a network provider.

> **Remember!**
>
> If your out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred that are above the recognized charge.
>
> These charges do not apply to your deductible or out-of-pocket maximum.

- The Plan pays out-of-network benefits only for the part of a covered expense that is considered the **recognized charge** (formerly called the reasonable and customary limit).
- Precertification is a process that determines whether the services being recommended are covered by the Plan.

Cost Sharing: Aetna Value HD Plans

Cost Sharing	Aetna Value HD 1500		Aetna Value HD 4000	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum				
	No lifetime maximum		No lifetime maximum	
Annual Plan Deductible				
Employee-only	$1,500	$1,500	$4,000	$4,000
Family	$3,000	$3,000	$8,000	$8,000
Annual Coinsurance Limit (does not include deductible)				
Employee-only	$1,000	$2,000	$1,000	$2,000
Family	$2,000	$4,000	$2,000	$4,000
Annual Out-of-Pocket Maximum (includes deductibles)				
Employee-only	$2,500	$3,500	$5,000	$6,000
Family	$5,000	$7,000	$10,000	$12,000

Covered Expenses: Aetna Value HD Plans

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Preventive Care*		
Routine Physical Exams • employee, spouse and children age 18 and older: 1 exam every 12 months	The Plan pays 100% No deductible	Not covered
Routine Well Child Care • 7 exams in the first 12 months of life • 3 exams in months 13-24 • 3 exams in months 25-36 • 1 exam every 12 months: age 3 to age 18	The Plan pays 100% No deductible	**Exams:** Not covered **Routine immunizations up to 12 months:** You pay 40% after the deductible

Covered Expenses: Aetna Value HD Plan

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Preventive Care*		
Screening and Counseling • obesity – up to age 22: unlimited visits – age 22 and over: up to 26 visits per calendar year (healthy diet counseling limited to 10 visits) • use of tobacco products: up to 8 counseling sessions per calendar year • misuse of alcohol or drugs: up to 5 visits per calendar year	The Plan pays 100% No deductible	Not covered
Routine Gynecological Exams • 1 routine exam and Pap smear per year	The Plan pays 100% No deductible	You pay 40% after the deductible
Routine Mammogram • age 35-39: 1 baseline mammogram • age 40 and older: 1 mammogram every 12 months	The Plan pays 100% No deductible	You pay 40% after the deductible
Prostate Screening • 1 annual prostate screening for men age 40 and over	The Plan pays 100% No deductible	Not covered
Vision and Hearing Care		
Routine Eye Exams • 1 exam every 12 months	You pay 20% after the deductible	Not covered
Routine Hearing Exams (for children age 15 and under) • 1 exam every 12 months	You pay 20% after the deductible	Not covered
Hearing Aids (for children age 15 and under) • $1,000 per hearing aid in a 24-month period	The Plan pays 100% No deductible	You pay 40% after the deductible

** The frequency of preventive care services is subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. For more information, contact your physician, log in to the Aetna website at **www.aetna.com** or call Member Services at the number on your ID card.*

Covered Expenses: Aetna Value HD Plans

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Vision and Hearing Care (cont'd)		
Precertification Precertification is required for: • Inpatient care in a hospital or treatment facility • Alternatives to hospital inpatient care: skilled nursing facility, hospice, private duty nursing and home health care • Certain other types of care (refer to Precertification for more information) Precertification is required for the services listed above so you know ahead of time whether the Plan will cover the services as medically necessary. ***If you do not get the required precertification, the care is not covered.*** Precertification can help you avoid paying for care out of your own pocket because it's not medically necessary.		
Outpatient and Specialty Care		
Office Visits • PCP office visits (general and family practitioners, internists, pediatricians) • specialist office visits	You pay 20% after the deductible You pay 20% after the deductible	You pay 40% after the deductible You pay 40% after the deductible
Walk-In Clinic	You pay 20% after the deductible	You pay 40% after the deductible
Allergy Testing and Treatment	You pay 20% after the deductible	You pay 40% after the deductible
Short-Term Rehabilitation		
Outpatient Therapy (speech, occupational and physical therapy) • physician's office up to 60 visits per condition per calendar year • outpatient facility	You pay 20% after the deductible You pay 20% after the deductible	You pay 40% after the deductible You pay 40% after the deductible
Treatment of Autism/Pervasive Developmental Disorders (for children under age 21)	You pay 20% after the deductible	You pay 40% after the deductible
Spinal Manipulation • up to 30 visits per calendar year	You pay 20% after the deductible	You pay 40% after the deductible (recognized charge is limited for SHBP members to $35 per visit)

Covered Expenses: Aetna Value HD Plans

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Family Planning		
Contraceptive Counseling • first 2 visits in a 12-month period • additional visits	The Plan pays 100% No deductible You pay 20% after the deductible	You pay 40% after the deductible You pay 40% after the deductible
Contraceptives (insertion/injection of contraceptives by your physician)	The Plan pays 100% No deductible	You pay 40% after the deductible
Note: Additional contraceptive coverage may be available through your prescription drug program. For more information, refer to the separate handbook describing your prescription drug coverage.		
Infertility Services (in accordance with New Jersey mandates) • diagnosis and treatment of the underlying cause of infertility • ovulation induction and artificial insemination • advanced reproductive therapies - up to 4 egg retrievals per lifetime	You pay 20% after the deductible You pay 20% after the deductible You pay 20% after the deductible	You pay 40% after the deductible You pay 40% after the deductible You pay 40% after the deductible
Voluntary Sterilization (men)	You pay 20% after the deductible	You pay 40% after the deductible
Voluntary Sterilization (women)	The Plan pays 100% No deductible	You pay 40% after the deductible
Maternity		
Physician's Services • initial visit to diagnose pregnancy • routine prenatal office visits*	You pay 20% after the deductible The Plan pays 100% No deductible	You pay 40% after the deductible You pay 40% after the deductible
Physician's Services: Delivery and Postnatal Care	You pay 20% after the deductible	You pay 40% after the deductible

** The benefits shown here are for routine prenatal care and services provided by your Ob/Gyn. Additional services such as laboratory tests and care that is required due to complications of pregnancy are not considered routine prenatal care. Call Member Services at the number shown on your ID card if you have questions about coverage for care during your pregnancy.*

Covered Expenses: Aetna Value HD Plans

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Maternity (cont'd)		
Breast Feeding Support and Supplies • lactation counseling visits 1-6 in a 12-month period • additional visits • breast pumps and supplies: 1 manual or electric breast pump per 36-month period *The electric pump must be purchased within 60 days from the date of your child's birth. The manual pump must be purchased within 12 months from the date of your child's birth.*	The Plan pays 100% No deductible You pay 20% after the deductible The Plan pays 100% No deductible, no copay	You pay 40% after the deductible You pay 40% after the deductible You pay 40% after the deductible
Hospital Care Precertification is required for inpatient care		
Inpatient	You pay 20% after the deductible	You pay 40% after the deductible
Outpatient	You pay 20% after the deductible	You pay 40% after the deductible
Surgery		
Inpatient Surgery	You pay 20% after the deductible	You pay 40% after the deductible
Outpatient Surgery	You pay 20% after the deductible	You pay 40% after the deductible

Covered Expenses: Aetna Value HD Plans

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Alternatives to Hospital Confinement Precertification is required		
Skilled Nursing Facilities • up to a combined maximum of 120 days per calendar year	You pay 20% after the deductible	You pay 40% after the deductible. Up to a maximum of 60 days per calendar year.
Home Health Care	You pay 20% after the deductible	You pay 40% after the deductible
Hospice Care	You pay 20% after the deductible	You pay 40% after the deductible
Private Duty Nursing	You pay 20% after the deductible	You pay 40% after the deductible
Testing and Therapy		
Chemotherapy or Radiation Therapy (outpatient)	You pay 20% after the deductible	You pay 40% after the deductible
X-Rays and Lab Tests	You pay 20% after the deductible	You pay 40% after the deductible
Durable Medical Equipment and Prosthetics		
Durable Medical Equipment (DME)	You pay 20% after the deductible	You pay 40% after the deductible
Prosthetic Devices	You pay 20% after the deductible	You pay 40% after the deductible
Emergency Care		
Emergency Room • in an emergency • non-emergency use of the emergency room	You pay 20% after the deductible Not covered	You pay 20% after the deductible Not covered

Covered Expenses: Aetna Value HD Plans

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Emergency Care (cont'd)		
Urgent Care Facility • urgent care treatment • non-urgent use of an urgent care facility	You pay 20% after the deductible Not covered	You pay 40% after the deductible Not covered
Ambulance (in an emergency)	You pay 20% after the deductible	You pay 20% after the deductible
Mental Health Treatment Precertification is required for inpatient care		
Inpatient Treatment	You pay 20% after the deductible	You pay 40% after the deductible
Outpatient Treatment	You pay 20% after the deductible	You pay 40% after the deductible
Treatment of Alcohol and Substance Abuse Precertification is required for inpatient, intensive outpatient, and partial hospitalization program care		
Inpatient Treatment	You pay 20% after the deductible	You pay 40% after the deductible
Outpatient Treatment • detoxification – no calendar year limit • rehabilitation	You pay 20% after the deductible	You pay 40% after the deductible
Prescription Drugs		
Outpatient Prescription Drugs	Please refer to the separate handbook describing your prescription drug coverage.	

AETNA FREEDOM PLANS: OVERVIEW

The Aetna Freedom plans allow you to use any licensed health care provider when you need care. When you choose a provider in the Aetna network, you lower your out of pocket costs because the Plan pays 100% of many covered expenses after you pay a copay. If you go out of network, you must pay a deductible, plus a percentage of the cost for the covered service, for most covered expenses.

There are four Aetna Freedom options:

- Aetna Freedom 10*
- Aetna Freedom 15
- Aetna Freedom 1525**
- Aetna Freedom 2030**
- Aetna Freedom 2035** (Available to active employees only)

** State active employees are not eligible for the Aetna Freedom 10 plan.*

*** Medicare eligible retirees are not eligible for the Aetna Freedom 1525, 2030 or 2035 options.*

Summary of Benefits: Aetna Freedom Plans

Keep in mind:

- The Plan pays benefits only for care that is necessary.
- A copay (or copayment) is a flat fee that you must pay at the time you receive a service.
- The deductible is the part of your covered expenses you pay before the Plan starts to pay benefits each year.
- The Plan's coinsurance is the percentage of covered expenses that the Plan pays after you satisfy the Plan's calendar year deductible. The coinsurance limit is the maximum you pay as your coinsurance share each year.
- Network providers have agreed to charge no more than the negotiated charge for a service or supply that is covered by the Plan. You are not responsible for amounts that exceed the negotiated charge when you get care from a network provider.
- The Plan pays out of network benefits only for the part of a covered expense that is considered the recognized charge (formerly called the reasonable and customary limit).

> **Remember!**
>
> If your **out-of-network provider** charges more than the recognized charge, you will be responsible for any expenses incurred that are above the recognized charge. These charges do not apply to your deductible, coinsurance limit or out of pocket maximum.

- Precertification is a process that determines whether the services being recommended are covered by the Plan.

Cost Sharing: Aetna Freedom 10

Cost Sharing	In-Network	Out-of-Network
Lifetime Maximum		
Individual	No lifetime maximum	No lifetime maximum
Copayments		
Primary Care Physician	$10	None
Specialist	$10	None
Emergency room	$50 — SHBP Members $25 — SEHBP Members	$50 — SHBP Members $25 — SEHBP Members
Inpatient (applies to confinements in a hospital, treatment facility, skilled nursing facility or hospice)	None	$200 deductible per confinement*
Annual Plan Deductible (includes 3-month deductible carryover)		
Individual	None	$100
Family	None	$250
Coinsurance		
Your coinsurance share	None, except 10% for: • private duty nursing • durable medical equipment • prosthetic devices • ambulance	20% after deductible
Annual Out-of-Pocket Maximum (includes copays and coinsurance)		
Individual	$400	$2,000
Family	$1,000	$5,000

* Inpatient deductible waived for local education employees.

Cost Sharing	In-Network	Out-of-Network
Lifetime Maximum		
Individual	No lifetime maximum	No lifetime maximum
Copayments		
Primary Care Physician	$15	None
Specialist	$15	None
Emergency room	$75 — SHBP Members $50 — SEHBP Members	$75 — SHBP Members $50 — SEHBP Members
Inpatient (applies to confinements in a hospital, treatment facility, skilled nursing facility or hospice)	None	$200 deductible per confinement*
Annual Plan Deductible (includes 3-month deductible carryover)		
Individual	None	$100
Family	None	$250
Coinsurance		
Your coinsurance share	None, except 10% for: • private duty nursing • durable medical equipment • prosthetic devices • ambulance	30% after deductible
Annual Coinsurance Maximum		
Individual	$400	Not applicable
Family	$1,000	Not applicable
Annual Out-of-Pocket Maximum (includes copays and coinsurance)		
Individual	$5,480 – Active Employees $5,499 – SHBP Retirees $5,439 – SEHBP Retirees	$2,000
Family	$10,960 – Active Employees $10,998 – SHBP Retirees $10,878 – SEHBP Retirees	$5,000

Cost Sharing	In-Network	Out-of-Network
Lifetime Maximum		
Individual	No lifetime maximum	No lifetime maximum
Copayments		
Primary Care Physician	$15	None
Specialist	$25	None
Emergency room	$100 — SHBP Members $75 — SEHBP Members	$100 — SHBP Members $75 — SEHBP Members
Inpatient (applies to confinements in a hospital, treatment facility, skilled nursing facility or hospice)	None	$200 deductible per confinement
Annual Plan Deductible (includes 3-month deductible carryover**)**		
Individual	None	$100
Family	None	$250
Coinsurance		
Your coinsurance share	None, except 10% for: • private duty nursing • durable medical equipment • prosthetic devices • ambulance	30% after deductible
Annual Coinsurance Maximum		
Individual	$400	Not applicable
Family	$1,000	Not applicable
Annual Out-of-Pocket Maximum (includes copays and coinsurance)		
Individual	$5,480 – Active Employees $5,499 – SHBP Retirees $5,439 – SEHBP Retirees	$2,000
Family	$10,960 – Active Employees $10,998 – SHBP Retirees $10,878 – SEHBP Retirees	$5,000

Cost Sharing: Aetna Freedom 15

Cost Sharing	In-Network	Out-of-Network
Lifetime Maximum		
Individual	No lifetime maximum	No lifetime maximum
Copayments		
Primary Care Physician	$20	None
Specialist: adult	$30	None
Specialist: Chidlren under age 26	$20	None
Emergency room	$125	$125
Inpatient (applies to confinements in a hospital, treatment facility, skilled nursing facility or hospice)	None	$500 deductible per confinement
Annual Plan Deductible (includes 3-month deductible carryover**)**		
Individual	None	$200
Family	None	$500
Coinsurance		
Your coinsurance share	None, except 10% for: • private duty nursing • durable medical equipment • prosthetic devices • ambulance	30% after deductible
Annual Coinsurance Maximum		
Individual	$800	Not applicable
Family	$2,000	Not applicable
Annual Out-of-Pocket Maximum (includes copays and coinsurance)		
Individual	$5,480 – Active Employees $5,499 – SHBP Retirees $5,439 – SEHBP Retirees	$5,000
Family	$10,960 – Active Employees $10,998 – SHBP Retirees $10,878 – SEHBP Retirees	$12,500

Cost Sharing: Aetna Freedom 1525

Cost Sharing	In-Network	Out-of-Network
Lifetime Maximum		
Individual	No lifetime maximum	No lifetime maximum
Copayments		
Primary Care Physician	$20	None
Specialist: adult	$35	None
Specialist: Chidlren under age 26	$35	None
Emergency room	$300	$300
Inpatient (applies to confinements in a hospital, treatment facility, skilled nursing facility or hospice)	None	$600 deductible per confinement
Annual Plan Deductible (includes 3-month deductible carryover**)**		
Individual	$200	$800
Family	$500	$2,000
Coinsurance		
Your coinsurance share	20% after deductible	40% after deductible
Annual Coinsurance Maximum		
Individual	$2,000	Not applicable
Family	$5,000	Not applicable
Annual Out-of-Pocket Maximum (includes copays and coinsurance)		
Individual	$5,480 – Active Employees	$6,500
Family	$10,960 – Active Employ-ees	$13,000

Cost Sharing: Aetna Freedom 2030

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Preventive Care*		
Routine Physical Exams • employee, spouse and children age 18 and older: 1 exam every 12 months	The Plan pays 100% No copay	Not covered
Routine Well Child Care • 7 exams in the first 12 months of life • 3 exams in months 13-24 • 3 exams in months 25-36 • 1 exam every 12 months: age 3 to age 18	The Plan pays 100% No copay	**Exams:** Not covered Routine immunizations for children under 12 months: You pay your coinsurance share after the deductible
Screening and Counseling • obesity – up to age 22: unlimited visits – age 22 and over: up to 26 visits per calendar year (healthy diet counseling limited to 10 visits) • use of tobacco products: up to 8 counseling sessions per calendar year • misuse of alcohol or drugs: up to 5 visits per calendar year	The Plan pays 100% No copay	Not covered
Routine Gynecological Exams • 1 routine exam and Pap smear per year for female members over age 21 in the Freedom and Value plans • 1 routine exam and Pap smear every 24 months for Medicare Advantage PPO ESA	The Plan pays 100% No copay	You pay your coinsurance share after the deductible
Routine Mammogram • age 35-39: 1 baseline mammogram • age 40 and older: 1 mammogram every 12 months	The Plan pays 100% No copay	You pay your coinsurance share after the deductible
Prostate Screening • 1 annual prostate screening for men age 40 and over	The Plan pays 100% No copay	Not covered

Cost Sharing: Aetna Freedom 2035

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Vision and Hearing Care		
Routine Eye Exams • 1 exam every 12 months	You pay the specialist copay, then the Plan pays 100%	Not covered
Routine Hearing Exams (for children age 15 and under) • 1 exam every 12 months	You pay the specialist copay, then the Plan pays 100%	You pay your coinsurance share after the deductible
Hearing Aids (for children age 15 and under) • $1,000 per hearing aid in a 24-month period	The Plan pays 100% No copay	You pay your coinsurance share after the deductible
Precertification Precertification is required for: • Inpatient care in a hospital or treatment facility • Alternatives to hospital inpatient care: skilled nursing facility, hospice, private duty nursing and home health care • Certain other types of care (refer to Precertification for more information) Precertification is required for the services listed above so you know ahead of time whether the Plan will cover the services as medically necessary. If you do not get the required precertification, the care is not covered. Precertification can help you avoid paying for care out of your own pocket because it's not medically necessary.		
Outpatient and Specialty Care		
Office Visits • PCP office visits (general and family practitioners, internists, pediatricians) • specialist office visits	You pay PCP copay, then the Plan pays 100% You pay specialist copay, then the Plan pays 100%	You pay your coinsurance share after the deductible
Walk-In Clinic	You pay PCP copay, then the Plan pays 100%	You pay your coinsurance share after the deductible
Allergy Testing and Treatment	You pay applicable (PCP/specialist) copay, then the Plan pays 100%	You pay your coinsurance share after the deductible

Covered Expenses: Aetna Freedom Plans

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Short-Term Rehabilitation		
Outpatient Therapy (speech, occupational and physical therapy) • physician's office - up to 60 visits per condition per calendar year • outpatient facility	You pay specialist copay, then the Plan pays 100% The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible You pay your coinsurance share after the deductible
Treatment of Autism/Pervasive Developmental Disorders (for children under age 21) • physician's office • outpatient facility	You pay specialist copay, then the Plan pays 100% The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible You pay your coinsurance share after the deductible
Spinal Manipulation • up to 30 visits per calendar year	You pay specialist copay, then the Plan pays 100%	You pay your coinsurance share after the deductible (recognized charge is limited for SHBP members to $35 per visit)
Family Planning		
Contraceptive Counseling • first 2 visits in a 12-month period • additional visits	The Plan pays 100% No copay You pay applicable (PCP/specialist) copay, then the Plan pays 100%	You pay your coinsurance share after the deductible You pay your coinsurance share after the deductible
Contraceptives (insertion/injection of contraceptives by your physician)	The Plan pays 100% No copay	You pay your coinsurance share after the deductible
Note: Additional contraceptive coverage may be available through your prescription drug program. For more information, refer to the separate handbook describing your prescription drug coverage.		

Covered Expenses: Aetna Freedom Plans

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Family Planning (cont'd)		
Infertility Services (in accordance with New Jersey mandates) • diagnosis and treatment of the underlying cause of infertility • ovulation induction and artificial insemination • advanced reproductive therapies - up to 4 egg retrievals per lifetime	You pay specialist copay, then the Plan pays 100%	You pay your coinsurance share after the deductible
Voluntary Sterilization (men) • physician's office • outpatient facility	You pay specialist copay, then the Plan pays 100% The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Voluntary Sterilization (women)	The Plan pays 100%	You pay your coinsurance share after the deductible
Maternity		
Physician's Services • initial visit to diagnose pregnancy • routine prenatal office visits*	You pay specialist copay, then the Plan pays 100% The Plan pays 100% No copay	You pay your coinsurance share after the deductible

** The benefits shown here are for routine prenatal care and services provided by your Ob/Gyn. Additional services such as laboratory tests and care that is required due to complications of pregnancy are not considered routine prenatal care. Call Member Services at the number shown on your ID card if you have questions about coverage for care during your pregnancy.*

Covered Expenses: Aetna Freedom Plans

Maternity (cont'd)		
Physician's Services: Delivery and Postnatal Care	The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Breast Feeding Support and Supplies • lactation counseling visits 1-6 in a 12-month period Additional Visits • breast pumps and supplies 1 manual or electric breast pump per 36-month period	The plan pays 100% No copay You pay applicable (PCP/ specialist) copay, then the Plan pays 100% The Plan pays 100% No copay	You pay your coinsurance share after deductible
The electric pump must be purchased within 60 days from the date of your child's birth. The manual pump must be purchased within 12 months from the date of your child's birth.		

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Hospital Care - Precertification is required for inpatient care		
Inpatient	The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the annual deductible and the inpatient deductible
Outpatient	The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible

Covered Expenses: Aetna Freedom Plans

Surgery		
Inpatient Surgery	The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Outpatient Surgery • physician's office • outpatient facility	You pay applicable (PCP/ specialist) copay, then the Plan pays 100% The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Bariatric (weight loss) Surgery	The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Alternatives to Hospital Confinement - Precertification is required		
Skilled Nursing Facilities • up to a combined maximum of 120 days per calendar year	The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the annual deductible and the inpatient deductible Maximum: 60 days per calendar year
Home Health Care	The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Hospice Care • **inpatient** • **outpatient**	The Plan pays 100% ***2035 plan -** *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the annual deductible and the inpatient deductible You pay your coinsurance share after the deductible

Covered Expenses: Aetna Freedom Plans

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Alternatives to Hospital Confinement (cont'd) - Precertification is required		
Private Duty Nursing	You pay 10% ***2035 plan -** You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Testing and Therapy		
Chemotherapy or Radiation Therapy (outpatient)	The Plan pays 100% ***2035 plan -** You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
X-Rays and Lab Tests (outpatient facility)	The Plan pays 100% ***2035 plan -** You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Durable Medical Equipment and Prosthetics		
Durable Medical Equipment (DME)	You pay 10% ***2035 plan -** You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Prosthetic Devices	You pay 10% ***2035 plan -** You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Emergency Care		
Emergency Room (ER) • in an emergency	You pay the emergency room copay, then the Plan pays 100%. The copay is waived if you are admitted to the hospital from the ER.	You pay the emergency room copay, then the Plan pays 100%. The copay is waived if you are admitted to the hospital from the ER.
• non-emergency use of the emergency room	Not covered	Not covered

Covered Expenses: Aetna Freedom Plans

Type of Service or Supply	In-Network Care (based on the negotiated charge)	Out-of-Network Care (based on the recognized charge)
Emergency Care		
Urgent Care Facility • urgent care treatment • non-urgent use of an urgent care facility	You pay the specialist copay, then the Plan pays 100% Not covered	You pay your coinsurance share after the deductible Not covered
Ambulance (in an emergency)	You pay 10% ***2035 plan** - *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Mental Health Treatment - Precertification is required for inpatient care		
Inpatient Treatment • mental/behavioral health services	The Plan pays 100% ***2035 plan** - *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the annual deductible and the inpatient deductible
Outpatient Treatment • mental/behavioral health services	You pay specialist copay, then the Plan pays 100%	You pay your coinsurance share after the deductible
Treatment of Alcohol and Substance Abuse - Precertification is required for inpatient, intensive outpatient, and partial hospitalization program care		
Inpatient Treatment • alcohol and substance abuse	The Plan pays 100% ***2035 plan** - *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible and the inpatient copay
Outpatient Treatment • alcohol and substance abuse	The Plan pays 100% ***2035 plan** - *You pay your coinsurance share after the deductible*	You pay your coinsurance share after the deductible
Prescription Drugs		
Outpatient Prescription Drugs	Please refer to the separate handbook describing your prescription drug coverage.	

HOW THE MEDICAL PLAN WORKS

The Plan pays benefits for covered expenses. You must be covered by the Plan on the date when you incur a covered medical expense. The Plan does not pay benefits for expenses incurred before your coverage starts or after it ends.

This section describes important features of the Plan. To learn how these features apply to the Plan, refer to the Summary of Benefits for your medical plan option.

The Provider Network

The Plan gives you the freedom to choose any doctor or other health care provider when you need medical care. How that care is covered and how much you pay out of your own pocket depend on whether the expense is covered by the Plan and whether you choose an **in-network provider** or an **out-of-network provider.**

Doctors, hospitals and other health care providers that belong to Aetna's network are called in network providers. The providers in the network represent a wide range of services, including:

- Primary care (general and family practitioners, pediatricians and internists)
- Specialty care (such as Ob/Gyns, surgeons, cardiologists and urologists)
- Health care facilities (hospitals, skilled nursing facilities)

When they join the network, providers agree to provide services or supplies for **negotiated charges.** To find an in network provider in your area:

- Use *DocFind®* at ***www.aetnastatenj.com*** Follow the prompts to select the type of search you want, the area in which you want to search and the number of miles you're willing to travel. You can search the online **directory** for a specific doctor, type of doctor or all the doctors in a given zip code and/or travel distance. For more about DocFind, turn to When You Need Help.
- *Call Member Services.* Member Services representative can help you find an in network provider in your area. You can also request a printed listing of in network providers in your area without charge. The Member Services' toll-free number is printed on your ID card.

The Primary Care Physician

While you are not required to choose a primary care physician (PCP), you and each covered member of your family have the option of selecting an internist, family care practitioner, general practitioner or pediatrician (for your children) to serve as your regular PCP. Your PCP can provide preventive care and treat you for illnesses and injuries. Regular preventive care is key to achieving good health, and a PCP can be your personal health care manager. He or she gets to know you and your special needs and problems, and can recommend a specialist when you need care that he or she can't provide. This can be very helpful, since it's often hard to choose the right specialist.

It's Your Choice

When you need medical care, you have a choice. You can select a doctor or facility that belongs to the network (an **in-network provider**) or one that does not belong (an **out-of-network provider**).

- ***If you use an in-network provider,*** you'll pay less out of your own pocket for your care. You won't have to fill out claim forms, because your in-network provider will file claims for you. In addition, your provider will make the necessary telephone call to start the precertification process when you must be hospitalized or need certain types of care. (See *Precertification* for more information.)
- ***If you use an out-of-network provider,*** you'll pay more out of your own pocket for your care. You'll be required to file your own claims and make the telephone call required for precertification. (See *Claims and Appeals* and *Precertification* for more information.)

The *Summary of Benefits* for your medical plan option shows how the Plan's level of coverage differs when you use in-network versus out-of-network providers. In most cases, you save money when you use in-network providers.

Provider Information

It is easy to get information about providers in Aetna's network using the Internet. With DocFind® you can conduct an online search for in-network doctors, hospitals and other providers. To use DocFind, go to ***www.aetnastatenj.com*** Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation.

You also may obtain, without charge, a listing of in network providers from your Plan Administrator, or by calling the toll free Member Services number on your ID card.

Key Terms

The following key terms are the foundation of the Plan:

Necessary Services and Supplies

The Plan pays benefits only for medically **necessary** services and supplies. Refer to the *Glossary* for a full definition of "necessary."

Negotiated Charge

In-network providers have agreed to charge no more than the negotiated charge for a service or supply that is covered by the Plan. You are not responsible for amounts that exceed the negotiated charge when you obtain care from a network provider.

Non-Occupational Coverage

The Plan covers only expenses related to **non-occupational** injury and **non-occupational disease.**

Recognized Charge

The Plan pays out-of-network benefits only for the part of a covered expense that is recognized.

Refer to the *Glossary* for more information about how Aetna determines the recognized charge for a service or supply.

> **Keep in Mind**
>
> If your out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred that are above the recognized charge.

Sharing the Cost of Care

You share in the cost of your medical care by paying deductibles, copays and coinsurance. These terms are explained below.

> **Keep in Mind**
>
> The features described in this section do not apply to every medical plan option. For example, the Aetna Value HD options do not have copays.
>
> Refer to the *Summary of Benefits* for each option to learn about the features that apply to that option.

Copays (copayments)

A **copay,** sometimes called a copayment, is a fee that you must pay at the time you receive some types of care. A copay does not apply toward your deductible or coinsurance limit.

A copay applies to:

- Physician office visits;
- Emergency room (ER) visits; and
- Prescription drug purchases.

Deductible

The deductible is the part of covered expenses you pay each plan year before the Plan starts to pay benefits.

<u>If you are enrolled in an Aetna Value HD plan:</u>

There are two levels of deductible under the Aetna Value HD options:

- **Employee-only:** If you elect coverage for yourself only, you must meet the employee-only deductible shown in the *Summary of Benefits* before the Plan begins to pay benefits each calendar year.
- **Family:** If you elect coverage for yourself and your dependents, the individual and family deductibles are combined. The Plan begins to pay benefits for all family members once the combined expenses of all family members reach the family deductible shown in the *Summary of Benefits.*

If you are enrolled in an Aetna Freedom plan: There are two types of plan-year deductible:

- **Individual:** The individual deductible applies separately to you and each covered person in your family. When a person's deductible expenses reach the deductible shown in the *Summary of Benefits,* the Plan will pay benefits for that person at the appropriate **coinsurance** percentage.
- **Family:** The family deductible applies to you and your family as a group. When the combined deductible expenses incurred by you and your covered family members reach the family deductible shown in the *Summary of Benefits,* the family deductible is met and the Plan will begin to pay benefits for all covered family members at the appropriate coinsurance percentage.

> **Keep in Mind**
>
> Copays, amounts above the **recognized charge** and penalties for failure to precertify out-of-network care do not count toward your annual deductible.

Deductible Carryover (Aetna Freedom plans only)

The Aetna Freedom plans have a deductible carryover provision. Any covered expenses that apply toward your deductible during the last three months of a calendar year may be applied toward the following year's deductible, too.

Coinsurance

Once you meet your deductible, the Plan begins paying benefits for covered expenses. The part you pay is called your coinsurance.

The Plan has different coinsurance levels for in-network and out-of-network care for each type of covered expense. Refer to the *Summary of Benefits* for your medical plan option for more information.

Coinsurance Limit

The Plan puts a limit on the amount you pay for coinsurance each year, called the coinsurance limit.

If you are enrolled in an Aetna Value HD plan:

- **Employee-only:** If you elect coverage for yourself only, you must reach the employee-only coinsurance limit shown in the *Summary of Benefits,* then the Plan pays 100% of your covered medical expenses for the rest of the calendar year.
- **Family:** If you elect coverage for yourself and dependents, the coinsurance amounts of all covered members apply toward the family coinsurance limit. The Plan begins to pay 100% of covered expenses for all family members once the coinsurance shares of all covered family members reach the coinsurance limit.

If you are enrolled in an Aetna Freedom plan:

- The individual coinsurance limit applies separately to each covered person in the family. Once a family member reaches the individual coinsurance limit shown in the *Summary of Benefits,* the Plan pays 100% of that person's covered medical expenses for the rest of the calendar year.
- The family coinsurance limit applies to the family as a group. When your family's combined coinsurance expenses satisfy the family coinsurance limit, the Plan pays 100% of the family's covered medical charges for the remainder of the calendar year.

Certain expenses do **not** apply toward the coinsurance limit:

- Deductibles;
- Copayment amounts;
- Expenses over the **recognized charge;**
- Penalties, including any additional out-of-pocket expenses you pay because you did not obtain the necessary precertification for a service; and
- Charges for services and supplies that are not covered by the Plan

> **Keep in Mind**
>
> After you reach the individual and/or family coinsurance limit for a plan year, you are still responsible for any copayments that apply**.**

Out-of-Pocket Maximum

The Plan puts a limit on the amount you pay for covered expenses out of your own pocket each year, called the **out-of-pocket maximum.**

If you are enrolled in an Aetna Value HD plan, your deductible and coinsurance amounts apply toward the out-of-pocket maximum shown in the *Summary of Benefits* as follows:

- **Employee-only: I**f you elect coverage for yourself only, you must reach the employee-only out-of-pocket maximum, then the Plan pays 100% of your covered medical expenses for the rest of the calendar year.
- **Family:** If you elect coverage for yourself and dependents, the out-of-pocket expenses of all covered members apply toward the family out-of-pocket maximum. The Plan begins to pay 100% of covered expenses for all family members once their combined out-of-pocket expenses reach the out-of-pocket maximum.

If you are enrolled in the Aetna Freedom plans, the out-of-pocket maximum shown in the *Summary of Benefits* applies to your in-network copay and coinsurance expenses as follows:

- The individual out-of-pocket maximum applies separately to each covered person in the family. Once a family member's in-network copay and coinsurance expenses reach the individual out-of-pocket maximum, the Plan pays 100% of that person's covered in-network medical expenses for the rest of the calendar year.
- The family out-of-pocket maximum applies to the family as a group. When your family's combined in-network copay and coinsurance expenses satisfy the family out-of-pocket maximum, the Plan pays 100% of the family's covered in-network medical expenses for the remainder of the calendar year.

Certain expenses do not apply toward the out-of-pocket maximum:

- Expenses over the **recognized charge;**
- Penalties, including any additional out-of-pocket expenses you pay because you did not obtain the necessary precertification for a service; and
- Charges for services and supplies that are not covered by the Plan.

Precertification

Precertification is a process that helps you and your **physician** determine whether the services being recommended are covered expenses under the Plan. It also allows Aetna to coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning) and to register you for specialized programs or case management when appropriate.

Precertification starts with a telephone call to Member Services:

- If you use an in-network provider, your provider will make this call for you.
- If you intend to receive care from an out-of-network provider, you must make the call to Aetna at the number shown on your ID card.

When You Need To Precertify Care

The services listed in the following chart must be precertified.

Type of Service	When You Need To Precertify Out-of-Network Care
Inpatient Care in a Hospital	
You must request precertification for inpatient confinement in an out-of-network hospital	To request precertification, call Aetna Member Services at **1-877-782-8365** as follows: • emergency admission: within 48 hours of admission or as soon as reasonably possible • urgent admission: before you are scheduled to be admitted • other admissions: at least 14 calendar days prior to admission
Alternatives to Hospital Inpatient Care	
You need to request precertification for the following hospital alternatives if your provider is not in the Aetna network: • skilled nursing facility care • hospice care – inpatient and outpatient • private duty nursing	To request precertification, call Aetna Member Services at **1-877-782-8365** as follows: • inpatient confinements: same as hospital inpatient care (above) • outpatient care: - non-emergency care – at least 14 calendar days in advance or as soon as reasonably possible - emergency care – as soon as reasonably possible

Type of Service	When You Need To Precertify Out-of-Network Care
Procedures and Treatments	
You need to request precertification for the following services, whether inpatient or outpatient: • accidental dental injuries • cancer clinical trials (injectables) • durable medical equipment - electric, customized or motorized wheelchairs and scooters and powered accessories - lymphedema pumps - neurostimulators • facial reconstruction or repair (including, but not limited to): - bone grafts - orthognathic surgery - osteotomies - surgical management of temporomandibular joint • hyperbaric oxygen therapy • infertility services – see Infertility Services for coverage information • radiology: - CT/CTA scans - diagnostic left heart catheterization - echo stress tests - MRI/MRA - nuclear medicine/nuclear cardiology - PET and PET/CT scans • reconstructive procedures that may be considered cosmetic: - blepharoplasty/canthopexy/canthoplasty - breast reconstruction/enlargement - excision of excessive skin due to weight loss - lipectomy or excess fat removal - pectus excavatum repair - rhinoplasty/rhytidectomy - sclerotherapy or surgery for varicose veins - any other potentially cosmetic procedure	To request precertification, call Aetna Member Services at **1-877-782-8365** as follows: • inpatient confinements: same as hospital inpatient care (above) • outpatient care: - non-emergency care – at least 14 calendar days in advance or as soon as reasonably possible - emergency care – as soon as reasonably possible

Type of Service	When You Need To Precertify Out-of-Network Care
Procedures and Treatments (cont'd)	
• specialty pharmaceuticals (including, but not limited to): - Botox - growth hormone - immunoglobin • specific medications administered in a physician's office or dialysis facility: - Aranesp - Epogen - Procrit • spinal disk surgeries (including, but not limited to): - discectomy - nucleoplasty - spinal fusion • surgery for morbid obesity (including, but not limited to): - gastric bypass - gastroplasty • transplants (including, but not limited to): - autologous bone marrow - autologous condrocyte - cornea - heart - kidney - liver - lung - pancreas • uvulopalatopharyngoplasty (UPPP)	To request precertification, call Aetna Member Services at **1-877-782-8365** as follows: • inpatient confinements: same as hospital inpatient care (above) • outpatient care: - non-emergency care – at least 14 calendar days in advance or as soon as reasonably possible - emergency care – as soon as reasonably possible
Inpatient Behavioral Health Care	
You need to request precertification for inpatient confinement in a hospital or treatment facility.	To request precertification, call Aetna Behavioral Health at **1-800-424-5679** as follows: • emergency admission: within 48 hours of admission or as soon as reasonably possible • urgent admission: before you are scheduled to be admitted • other admissions: at least 14 calendar days prior to admission

Type of Service	When You Need To Precertify Out-of-Network Care
Outpatient Behavioral Health Care	
Precertification is recommended for certain services. You should call Aetna Behavioral Health for the following services: • biofeedback • neuropsychological testing • outpatient detoxification • outpatient electroconvulsive therapy • psychiatric home care services • psychological testing Precertification is recommended for these services so you know ahead of time whether the Plan will cover the services and the benefit level that will apply. If, however, you do not get these services precertified, there is no penalty, as long as they are deemed medically necessary.	To request precertification, call Aetna Behavioral Health at **1-800-424-5679** as follows: • outpatient care: - non-emergency care – at least 14 calendar days in advance or as soon as reasonably possible - emergency care – as soon as reasonably possible

Aetna will notify you, your **physician** and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days must be certified. You, your physician or the facility will need to call Aetna at the number on your ID card no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a copy of this letter.

If You Don't Precertify

If you don't call when required, the medical plan may apply a penalty or deny coverage for your expenses. Refer to the *Summary of Benefits* for your medical plan option to find out the penalty that applies to your medical option.

If Precertification is:	Then charges are:
Requested and approved	Covered
Requested and denied	Not covered. You may appeal, as described in *Claims and Appeals*
Not requested	Not covered. You may appeal, as described in *Claims and Appeals*

Ongoing Reviews

Some services are ongoing in nature. The Plan requires periodic reviews of certain types of ongoing care to ensure that the care continues to be medically appropriate. Based on your claim activity, Aetna will review the following services throughout the course of treatment:

- Durable medical equipment
  - — all rentals
  - — bone stimulators
  - — electric beds/Clinitron/powered hospital beds/air mattresses/powered accessories
  - — enteral formula
  - — external defibrillators
- Home health care services
- Home hospice services
- Home infusion (IV) therapy
- Hospital-based weight loss programs
- Lyme disease intravenous antibiotic therapy
- Pain management
- Percutaneous laser disk surgery
- Therapy services
  - — cognitive therapy
  - — occupational therapy
  - — physical therapy
  - — speech therapy

Your ID Card

You will receive an ID card when you enroll in the Plan. You are encouraged to carry your ID card with you at all times. Present the card to medical providers before receiving services. If your card is lost or stolen, please notify Aetna immediately. You can print a temporary ID card on Aetna Navigator – log in, then follow the instructions under *Get an ID Card.*

YOUR MEDICAL 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 necessary.

Certain services must be precertified by Aetna. When your care is in-network, your provider is responsible for obtaining this approval. You are responsible for obtaining the required precertification for out-of- network care. See *Precertification* for more information.

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.

> **Out-of-Network Preventive Care**
>
> Some preventive care is not covered when obtained from an out-of-network provider. Check the Summary of Benefits for your medical plan option.

The Plan covers:

- Routine physical examinations.
- Well child care from birth, including immunizations and booster doses.
- Charges made by your physician for screening and counseling in an individual or group setting for:
  - — obesity: services to help you lose weight if you are obese, including preventive counseling visits, medical nutrition therapy and nutritional counseling.
  - — use of tobacco products: services to help you stop using tobacco products, including preventive counseling visits, treatment visits and class visits.
  - — misuse of alcohol and/or drugs: services to help prevent or reduce the use of alcohol or controlled substances, including preventive counseling visits, risk factor reduction intervention and a structured assessment.

The Plan's preventive care coverage includes the following services for women:

- — screening and counseling services for:
  - interpersonal and domestic violence,
  - sexually transmitted diseases (up to two occurrences per year), and
  - Human Immune Deficiency Virus (HIV).
- — high risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- — screening for gestational diabetes.
  - Routine immunizations (except those required for travel or work).
  - Routine gynecological examinations and Pap smears.
  - Routine cancer screening, including:
- — mammograms for women.

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

- — for those at average risk for colorectal cancer:
  - one colonoscopy every 10 years; or
  - one sigmoidoscopy every 5 years; or
  - one double contrast barium enema every 5 years.

Vision and Hearing Services

The Plan covers:

- Periodic eye examinations.
- Audiometric hearing exams for children age 15 and under when the exam is performed by:
  - — an otolaryngologist or otologist, or
  - — an audiologist who:
- is legally qualified in audiology or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association, and
- performs the exam at the written direction of an otolaryngologist or otologist.
- Hearing aids, including fitting and repair, for children age 15 and under. The Plan does not cover:
  - — any hearing device or service that does not meet professionally acceptable standards, or
  - — any tests, appliances and devices to:
- enhance other forms of communication to compensate for hearing loss, or
- simulate speech.

> **Out-of-Network Care May Not Be Covered**
>
> Some vision and hearing services are covered only in-network. Check the Summary of Benefits for your medical plan option to see whether a service is covered when obtained from an out-of-network provider.

Outpatient and Specialty Care

Office Visits

The Plan covers treatment by a doctor in his or her office. The Plan may pay different benefits for PCP office visits and specialist office visits – refer to the Summary of Benefits for your medical plan option for details.

Coverage includes:

- Office visits with your PCP;
- Treatment for illness and injury;
- Allergy testing and treatment;
- Specialist consultations, including second opinions;
- Immunizations for infectious disease; and
- Supplies, radiology services, X-rays and tests given by the physician.

> **Keep in Mind**
>
> The Plan does not cover immunizations that are needed only for travel or employment.

Acupuncture

The Plan covers acupuncture when **necessary** for pain management and administered by a licensed acupuncturist or physician (M.D. or D.O.), including treatment of:

- Chronic low back pain. (Maintenance treatment, where the patient's symptoms are neither regressing nor improving, is not considered medically necessary.)
- Migraine headache.
- Pain from osteoarthritis of the knee or hip.
- Post-operative dental pain.
- Temporomandibular disorders (TMD).

> **For More Information**
>
> Refer to Aetna's Clinical Policy Bulletin to learn more about coverage for acupuncture. You can find the CPBs at ***www.aetna.com***

Walk-In Clinics

A walk-in clinic is a free-standing health care facility. The Plan covers visits to walk-in clinics for non-emergency treatment of an illness or injury, and for administration of certain immunizations.

> **Keep in Mind**
>
> Walk-in clinics are **not** an alternative to emergency room services, and they do not provide ongoing physician care.

Short-Term Therapy

The Plan covers:

- 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.
- 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.

Treatment of Autism/Pervasive Developmental Disorder (PDD)

The Plan covers the following for children under age 21:

- Screening and diagnosis of autism or another PDD.
- Medically necessary physical therapy, occupational therapy and speech therapy services for the treatment of autism or another PDD.
- Medically necessary behavioral interventions (ABA therapy) for children under 21 years of age who have been diagnosed with autism.
- The Family Cost Share portion of expenses incurred for certain health care services obtained through the New Jersey Early Intervention System (NJEIS).

> **Keep in Mind**
>
> ABA therapy is not covered for children with developmental diagnoses.
>
> ABA therapy must be medically necessary and approved in advance by Aetna Behavioral Health.

Spinal Manipulation

The Plan covers spinal manipulation services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a musculoskeletal problem or subluxation that could be documented by diagnostic X-rays.

Family Planning

Contraception Services

The Plan covers the following contraceptive services and supplies when obtained from, and billed by, your physician:

- Contraceptive counseling.
- Contraceptive devices prescribed by a physician.
- Office visit for the injection of injectable contraceptives.
- Related outpatient services such as consultations, exams and procedures.

Brand contraceptive drugs and devices may be excluded from formulary and/or include copayments or deductibles as long as a therapeutically equivalent generic contraceptive drug or 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.

Infertility Services

The Plan's coverage of infertility services follows the New Jersey state mandate for Infertility.

Coverage includes services to diagnose and treat infertility for both males and females. 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.
- Diagnostic evaluations.
- Sperm washing or preparation.
- Assisted hatching.
- Egg retrieval:
  - — When 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.
- Fresh and frozen embryo transfer.
- Ovulation induction.
- Artificial insemination.
- Advanced reproductive therapies:
  - — Gamete intrafallopian transfer (GIFT).
  - — Zygote intrafallopian transfer (ZIFT).
  - — Intracytoplasmic sperm injections (ICSI).
  - — In vitro fertilization (IVF), including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier.
- The services of an embryologist.

Coverage for Prescription Drugs to Treat Infertility

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 must be comparable to the SHBP/SEHBP prescription drug plans and must provide coverage for infertility medications for covered members and donors. Refer to the separate handbook describing your prescription drug coverage for more information.

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.

Infertility Exclusions

The Plan does not cover the following infertility services:

- Reversal of male and female voluntary sterilization.
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal.
- Non-medical costs of an egg or sperm donor. Medical costs of donors, including office visits, medications, laboratory and radiological procedures and retrieval, are covered until the donor is released from treatment by the reproductive endocrinologist.
- Purchase of donor sperm.
- Storage of sperm.
- Purchase of donor eggs.
- Cryopreservation or storage of cryopreserved eggs or embryos.
- Any experimental, investigational or unproven infertility procedures or therapies.
- All charges associated with gestational carrier programs, for either the covered person or the gestational carrier.
- 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.
- The number of covered embryo transfers are limited by the number of eggs retrieved in the lifetime maximum of 4 completed egg retrievals, or are 46 years of age and older.
- Infertility services that are not reasonably likely to be successful.
- Services received by a spouse or partner who is not covered by the Plan.
- Services and supplies obtained without the necessary claim authorization from Aetna's Infertility Case Management Unit.

Voluntary Sterilization

The Plan covers vasectomy or tubal ligation performed by a physician or hospital. The Plan does not cover the reversal of a sterilization procedure.

Maternity

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).

If you are pregnant at the time you join the Plan, coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Breast Feeding Support, Counseling and Supplies

The Plan covers:

- Breast feeding assistance, training and counseling services by a certified lactation support provider in a group or individual setting.
- Purchase of a standard (not hospital-grade) electric breast pump, if you have not purchased either a standard electric or a manual pump within the past three years. The pump must be purchased within 60 days from the date of birth.
- Purchase of a manual breast pump, if you have not purchased either a standard electric or a manual pump within the past three years. The pump must be purchased within 12 months from the date of birth.
- Purchase of the accessories needed to operate the breast pump.

If you use a breast pump from a prior pregnancy, the Plan covers the purchase of a new set of breast pump supplies within the first 12 months following the birth.

Hospital Care

Inpatient Care

If you are confined as an inpatient, the Plan covers the services listed below. See Behavioral Health for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your PCP) while confined to a hospital.
- Intensive or special care facilities.
- Visits by your physician while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the hospital.
- Use of operating rooms and related facilities.

- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood. (The blood or blood product itself is not covered, see page 47.)
- 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.
- Magnetic resonance imaging.

Outpatient Care

The Plan covers charges made by a hospital for services and supplies provided on an outpatient basis.

Surgery

The Plan covers:

- Outpatient surgery for a covered surgical procedure.
- Preoperative and postoperative care.
- Casts and dressings.
- Oral surgery needed to:
  - treat a fracture, dislocation or wound.
  - cut out:
    - teeth partly or completely impacted in the jaw bone (bony impacted teeth),
    - other teeth that can't be removed without cutting into the bone, or
    - tumors or other diseased tissues.
  - change the jaw, jaw joints or bite relationships using a cutting procedure when appliance therapy alone can't improve function.
  - treat an accidental injury to sound natural teeth or tissues of the mouth. The treatment must occur within the same plan year of the accident, or in the following plan year. At the time of the accident, the teeth must have been free from decay (or in good repair) and firmly attached to the jaw bone.
- 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.

- Weight loss (bariatric) surgery. The Plan covers inpatient or outpatient charges made by an in-network hospital or physician for the medically necessary surgical treatment of morbid obesity. Bariatric surgery must be approved in advance by Aetna. The Plan does, in addition, cover out-of-network bariatric surgery for the medically necessary surgical treatment of morbid obesity.

Coverage includes one morbid obesity surgical procedure, including related outpatient services, within a two-year period that starts with the date of the first surgical procedure to treat morbid obesity, unless a multistage procedure is planned.

Refer to Aetna's Clinical Policy Bulletins to learn more about coverage for weight loss surgery. You can find the CPBs at ***www.aetna.com***

Keep in Mind

The Plan does not cover bariatric surgery when done for cosmetic reasons.

Institutes of Quality® for Bariatric Surgery

The Institutes of Quality (IOQ) for Bariatric Surgery give you access to a provider network that specializes in bariatric surgery. Each facility in the IOQ network has been selected based on quality of care, patient safety and efficiency standards.

You are encouraged to use IOQ facilities because of their experience with these procedures.

To Find an IOQ Bariatric Surgery Facility

Use the online DocFind directory at ***www.aetna.com*** to find providers in the IOQ for Bariatric Surgery network. Go to DocFind, click on the *Advanced Search* tab and select:

- Search for — click on Hospitals
- Provider type — click on *Medical Hospitals*
- Programs and Recognitions — click on Institutes of *Quality Bariatric Surgery Facility*

Transplants

The Plan covers:

- Evaluation.
- Compatibility testing of prospective organ donors who are immediate family members.
- Charges for activating the donor search process with national registries.
- The direct costs of obtaining the organ. Direct costs include surgery to remove the organ, organ preservation and transportation, and the hospitalization of a live donor, provided that the expenses are not covered by the donor's group or individual health plan.

- Physician or transplant team services for transplant expenses.
- Hospital inpatient and outpatient supplies and services, including:
  - — physical, speech and occupational therapy,
  - — biomedicals and immunosuppressants,
  - — home health care services,
  - — home infusion services, and
  - — follow-up care.

As part of the transplant benefit, the Plan does **not** cover:

- Services and supplies provided to a donor when the recipient is not covered by this Plan;
- Outpatient drugs, including biomedicals and immunosuppressants, that are not expressly related to an outpatient transplant occurrence;
- Home infusion therapy after the transplant coverage period ends;
- Harvesting or storage of organs without the expectation of an immediate transplant for an existing illness;
- Harvesting or storage of bone marrow, tissue or stem cells without the expectation of a transplant to treat an existing illness within 12 months; or
- Cornea or cartilage transplants unless otherwise preauthorized by Aetna.

Aetna offers a wide range of support services to those who need a transplant or other complex medical care. If you need a transplant, you or your physician should contact Aetna's National Medical Excellence Program® at **1-877-212-8811.** A nurse case manager will provide the support that you and your physician need to make informed decisions about your care.

The Institutes of Excellence™ Network

Through the Institutes of Excellence™ (IOE) network, you have access to a provider network that specializes in transplants. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

The Plan covers the transplant as **in-network care** only when it is performed at an IOE facility. Transplants performed at any non-IOE facility are covered as **out-of-network care,** even if the facility is considered in-network for other types of care.

Sexual Reassignment Surgery

The Plan covers medically necessary sexual reassignment surgery when certain criteria are met. For more information, refer to Aetna's Clinical Policy Bulletins at ***www.aetna.com***

Cosmetic Surgery Is Not Covered

The Plan does not cover cosmetic services and supplies related to sexual reassignment:

- Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords) and skin resurfacing used in feminization are considered cosmetic.
- Chin implants, nose implants, and lip reduction to assist masculinization are considered cosmetic.

Alternatives to Hospital Confinements

The Plan covers:

- Confinement in a **skilled nursing facility,** up to the maximum shown in the *Summary of Benefits* for your medical plan option, including:
  - — **room and board charges,** up to the **semi private room rate.** The Plan covers up to the private room rate if it is appropriate because of an infectious illness or a weak or compromised immune system.
  - — general nursing services.
  - — use of special treatment rooms.
  - — radiology services and lab work.
  - — oxygen and other gas therapy.
- Home health services provided by a 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 the services are necessary for the treatment of your medical condition.
- Confinement in semi private accommodations in a hospice care facility for a Plan participant who is diagnosed as **terminally ill.**
- Outpatient hospice services when a Plan participant 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.
  - — bereavement counseling.
  - — respite care. This is care provided when the patient's family or usual caretaker cannot care for the patient.

Note: *The Plan does **not** cover the following hospice services:*

- 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.
- Private duty nursing, when provided in your home.

Note: *Private duty nursing services must be medically necessary. Custodial care is **not** covered.*

Outpatient Testing and Therapy

The Plan covers:

- Cancer chemotherapy.
- Diagnostic laboratory and X-ray services.
- Radiation therapy.

Durable Medical Equipment and Prosthetics

The Plan covers:

- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury.

  The Plan covers instruction and appropriate services required for you to properly use the item, such as attachment or insertion. 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 to buy a replacement than to repair the existing equipment or rent like equipment.

  Coverage for Blood

  Blood, blood plasma, or other blood derivatives or substitutes are covered as durable medical equipment. The Plan does not cover blood or blood products that have been donated or replaced on behalf of the patient.

- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). The Plan's coverage of prosthetics includes:

  — an artificial arm, leg, hip, knee or eye,

  — an eye lens,

  — an external breast prosthesis and the first bra made solely for use with the prosthesis after a mastectomy,

  — a breast implant after a mastectomy,

  — foot orthotics prescribed by a physician and custom made to fit your measurements, and

  — a cardiac pacemaker.

Behavioral Health

The Plan includes coverage for behavioral health care. You receive a higher level of benefits for inpatient and outpatient mental health and substance abuse treatment that is given by a **behavioral health provider** in the Aetna Behavioral Health network. Out-of-network care is covered, too, but at a lower level of benefits. Refer to the *Summary of Benefits* for your medical plan option for a comparison of in-network and out-of-network behavioral health care benefits.

To be covered by the Plan, the care must be for:

- The effective treatment of alcohol or substance abuse; or
- The effective treatment of a mental disorder.

> **Keep in Mind**
> Certain types of care must be precertified. See *Precertification* for more information.

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 Substance Abuse

The Plan covers the following services for treatment of alcohol and substance abuse:

- **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 a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services.
- **Outpatient** visits to an in-network 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.

Emergency Care

In an Emergency

The Plan covers **emergency care** provided in a hospital emergency room or a free standing emergency facility. The care must be for an emergency condition.

The emergency care benefit covers:

- Use of emergency room facilities;
- Emergency room physician services;
- Hospital nursing staff services; and
- Radiology and pathology services.

> **Keep in Mind**
> The Plan does not cover non-emergency care in an emergency room.

If you are admitted to the hospital following emergency room treatment, remember that hospital admissions must be precertified (see Precertification for details).

Examples of medical emergencies include:

- heart attack or suspected heart attack
- poisoning or suspected poisoning
- severe shortness of breath
- uncontrolled or severe bleeding
- loss of consciousness
- severe burns
- high fever (especially in an infant)

Urgent Care

The Plan covers the services of a hospital or **urgent care provider** to evaluate and treat an **urgent condition**. Urgent care providers are physician-staffed facilities offering unscheduled medical services.

The urgent care benefit covers:

- Use of urgent care facilities;
- Physician services;
- Nursing staff services; and
- The services of radiologists and pathologists.

Examples of urgent medical conditions include:

- earaches
- fever
- severe vomiting
- sore throat

> **Keep in Mind**
> The Plan does not cover non-urgent care given by an urgent care provider.

What the Medical Plan Does Not Cover

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except as described in Acupuncture.
- 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.
- Biofeedback, except as specifically approved by Aetna.
- Breast augmentation and reduction, including treatment of gynecomastia, except when medically necessary.
- 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.
- Charges for a service or supply furnished by an in-network provider that exceed the provider's negotiated charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the Plan are paid.
- Charges for out-of-network care that exceed the recognized charge for the service or supply, as determined by Aetna.
- Charges for services and supplies:
  - — furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
  - — furnished, paid for, or for which benefits are provided or required under any law of a government. This exclusion will not apply to "no fault" auto insurance if it: a) is required by law; b) is provided on other than a group basis; and c) is included in the definition of "other group plans" in Coordination With Other Plans. In addition, this exclusion will not apply to: a) a plan established by a government for its own employees or their dependents; or b) Medicaid.
- Charges that a covered person is not legally obliged to pay.
- Contraceptives, except as described in Contraception Services.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve or alter appearance or self esteem, whether or not for psychological or emotional reasons. However, the Plan covers the following:
  - — reconstructive surgery to correct the results of an injury.
  - — surgery to improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as the result of:
    - a congenital defect (such as cleft lip and cleft palate), or
    - disease, or

- surgery performed to treat a disease or injury.

— 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.
- Custodial care and rest cures.
- Dental care and treatment, except as described under Your Medical Benefits.
- Except as described in Short Term Therapy, educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders; behavioral training; or cognitive rehabilitation. 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.
- Eyeglasses, vision aids and communication aids.
- 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.
- 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.
- Marriage, family, child, career, social adjustment, pastoral or financial counseling.
- Orthopedic shoes or other devices to support the feet.

  Note: *Foot orthotics are covered as a prosthetic device when prescribed by a physician and custom made to fit your measurements. Over the counter foot orthotics are not covered.*
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies 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.
- Prescription drugs and medicines, except those administered while you are an inpatient in a health care facility.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Reversal of voluntary sterilizations, including related follow up care.

- Services and supplies not medically necessary, as determined by Aetna, for the diagnosis, care or treatment of the disease or injury involved. This applies even if they are prescribed, recommended or approved by your attending physician or dentist.
- Services of a resident physician or intern rendered in that capacity.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services or supplies that are considered to be experimental or investigational. Refer to the *Glossary* for a definition of "experimental or investigational."
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- 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.
- 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 injectable drugs, including:
  - — experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,
  - — needles, syringes and other injectable aids,
  - — drugs related to treatments not covered by the Plan, and
  - — drugs related to the treatment of infertility and performance enhancing steroids.
- 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, unless resulting from disease, injury or congenital defects.

* This exclusion does not apply to employer-mandated physical examinations that are a prerequisite to participation in a physical fitness test that is required as a condition of continuing employment. Such exams are covered in-network only.

- Surgical operations, procedures or treatment of obesity, except where mandated by law.
- Therapy or rehabilitation, including (but not limited to):
  - — primal therapy.
  - — chelation therapy.
  - — rolfing.
  - — psychodrama.
  - — megavitamin therapy.
  - — purging.
  - — bioenergetic therapy.
  - — vision perception training.
  - — carbon dioxide therapy.
- Thermograms and thermography.
- Treatment in a federal, state or governmental facility, including care and treatment provided in an out of network 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 covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- 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 as described under *Your Medical Benefits.*
- 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 that does. If you are covered under a Workers' Compensation law or similar law, and submit proof that you are not covered for a particular disease or injury under such law, that disease or injury will be considered "non occupational," regardless of cause.
- Weight reduction programs that are not supervised by your physician (including, but not limited to, Weight Watchers and Jenny Craig) and dietary supplements (including, but not limited to, vitamins and protein shakes).

PRESCRIPTION DRUG PROGRAM

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.*

SPECIAL PROGRAMS

As a member of the Plan, you may take advantage of the value-added programs described in this section.

Discount Programs

You are eligible for discounts on health and wellness services and supplies. To learn more about these discounts, visit your secure member website at ***www.aetna.com***

- Fitness services
- Hearing services and supplies
- Savings on natural therapies and products
- Vision services and supplies
- Weight loss products and programs

Health Management Programs

Beginning Right℠ Maternity Program

This program helps pregnant women stay well and deliver healthier babies. It provides:

- Information on prenatal care, labor and delivery, newborn care and more;
- A pregnancy risk survey to see if you're at risk for certain complications;
- Extra support from obstetrically trained nurse case managers if you're at risk;

- A preterm labor prevention program that offers educational information on the risks of preterm labor and delivery, telephone outreach and follow up; and
- Smoke Free Moms to Be®, a nicotine-free smoking cessation program designed specifically for pregnant women.

How Do I Get Information About This Program?

As soon as Aetna is notified of your pregnancy, an Aetna nurse calls you to get things started. Or you can call and enroll yourself at: **1-800-CRADLE (1-800-272-3531).**

When you participate in this program, all your care is coordinated by your Ob/Gyn and Aetna case managers.

Simple Steps To A Healthier Life®

This personalized online health and wellness program offers resources to help you eat better, get in shape, relieve stress and more. The program can help you discover convenient ways to achieve a healthier, more balanced life.

This program features:

- A health assessment to help you identify your health needs;
- Personalized health reports and a one page *health summary* to share with your doctor, all based on your completed assessment;
- A personalized action plan recommending online programs in areas such as nutrition, fitness, stress relief and smoking cessation – chosen for you based on your health needs; and
- Interactive tools such as the Diet Manager, Walking Challenge, Healthy Shopping List and Fitness Planner.

Tailor the program to meet your needs and lifestyle by choosing the resources that are right for you. To get started, log in to your secure member website at ***www.aetna.com***

Disease Management Programs

ActiveHealth Disease Management Program – Active and Early Retirees only

Not everyone can be perfectly healthy. But, even with an ongoing health condition, we can provide support to help you achieve your best level of personal health. Our support programs can help you and your family members:

- Understand your condition
- Answer questions about treatment plans, medications and care management
- Better manage your condition
- Make lifestyle changes that can help, or sometimes reverse your condition
- Identify and manage potential risks for other conditions

We provide support for more than 35 conditions, including bone and joint, kidney, as well as cancer and diabetes.

How the program works – As an example let's say you have diabetes. You may contact ActiveHealth Management to join the program, or we may contact you to see if you want help managing your health concerns. Our nurses can then teach you about your condition and send you information as well as provide you with resources to keep you on track. They will also help to review your treatment plan and the medications that your doctor recommends. We have a 24-hour line for you to contact with support. After you speak with a nurse, you will receive follow-up communication, which will list the points discussed and the steps you should take before your next discussion with a nurse. Our support team can help you to learn how to protect yourself against future health problems. Visit ***www.aetnastatenj.com*** for additional information under "Wellness".

Aetna Health Connections℠ Disease Management Program – Medicare Eligible only

Aetna Health Connections Disease Management program is designed to help you achieve your optimal health by providing information, support and tools to help you make smarter health decisions. The program combines education, counseling, self-care, physician support and state-of-the-art technology to help you manage chronic medical conditions, including asthma, diabetes, certain cancers, arthritis, Crohn's disease, cystic fibrosis and HIV. The program emphasizes lifestyle changes to help you avoid complications and improve the quality of your life.

Aetna Health Connections can help you:

- Get the most appropriate treatment and preventive care for your individual needs;
- Understand how to follow your doctor's treatment plan and understand your treatment options;
- Take charge of your own health and manage your chronic conditions well;
- Make changes to reach your personal health goals; and
- Identify and manage your risks for other conditions.

If you have one of 30 chronic conditions, the program offers you support using educational materials and online resources. It also offers nurse case management for those at high risk.

Participation is voluntary. If you have a chronic disease supported by the program or if you are at risk of developing a chronic condition, you can call Member Services at the number on your ID card or submit a request to participate through Aetna Navigator® at ***www.aetnastatenj.com*** In addition, your physician may refer you to the program or Aetna may identify you as a potential participant based on your medical and prescription drug claim activity.

If you decide to take advantage of the program's services, a nurse will work with you, and your care will be monitored for potential problem areas or concerns.

Advanced Illness Resources

The Aetna Compassionate Care℠ program offers service and support when you are facing difficult decisions about an advanced illness. The program's nurse case managers work with doctors to:

- Arrange for care and manage benefits;
- Find resources for the patient and family members; and
- Help family members and other caregivers manage the patient's pain and symptoms.

Call Aetna Member Services to talk with a nurse case manager about the Aetna Compassionate Care program. Online support is also available at ***www.aetnacompassionatecare.com***

Transplant Support: The National Medical Excellence Program®

The National Medical Excellence Program (NME) helps you receive care from nationally recognized doctors and facilities experienced in performing organ transplants, bone marrow transplants and other complicated procedures. For patients who take part in this program, the Plan pays benefits for covered medical expenses incurred for the NME procedures and treatment types listed in this section. The program includes:

- *National Transplant Program* – coordinates care and provides access to covered treatment through the Institutes of Excellence™ Transplant Network.
- *National Special Case Program* – assists members with rare or complex conditions requiring specialized treatment in evaluating treatment options and obtaining appropriate care.
- *Out of Country Care Program* – supports members who need emergency inpatient medical care while temporarily traveling outside the United States.

These services must be preauthorized by Aetna.

Travel and Lodging

When NME arranges for treatment at a facility more than 100 miles from your home, the Plan provides travel and lodging allowances for you and one **companion,** including round trip (air, train or bus) transportation costs (coach class only), or mileage, parking and tolls if traveling by auto.

Benefits for travel and lodging expenses are subject to a maximum of $10,000 per transplant or procedure. Lodging expenses are subject to a $50 per night maximum per person, or $100 per night total.

The Plan will pay for travel and lodging expenses beginning on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest of:

- One year after the day a covered procedure was performed; or
- On the date you cease to receive any services from the program provider in connection with the covered procedure; or
- On the date your coverage terminates under the Plan.

The Plan covers only those services, supplies and treatments considered necessary for your medical condition. The Plan does not cover treatment considered **experimental or investigational** (as determined by Aetna).

Keep in Mind

Travel and lodging expenses must be approved in advance by Aetna. The Plan does not cover expenses that are not approved.

Inpatient and partial-hospitalization care must be precertified by Aetna. Refer to *Precertification* for more details about precertification procedures.

ELIGIBILITY

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.

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 call the Division of Pensions and Benefits, Office of Client Services at (609)-292-7524.

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 his or her 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 fewer 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 his or her 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's/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 mental or physical 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 and retirees, and their dependents, are receiving health care coverage under the program. 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 enrollment application.

New Jersey residents can obtain records from the State Bureau of Vital Statistics and Registration website ***http://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 websites: ***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.

**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 (cont'd)

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" 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.*

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 or civil union, birth certificates or 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.

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 the instance 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, 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 bistate 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.

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 website at:
www.nj.gov/treasury/pensions/health-benefits.shtml

IMPORTANT! Medicare Coverage Is Required if Eligible

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, P.O. 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 an Aetna Medicare Plan 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 his or her Part B coverage, the Centers for Medicare and Medicaid Services (CMS) terminates the Aetna Medicare Plan 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. You may not 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 that is immediately prior to his/her 65th birthday.

For members who are Medicare eligible and enrolled in an Aetna Medicare Plan, the Aetna Medicare Plan 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 an Aetna Medicare Plan, the Aetna Medicare Plan 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 his or her 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, when 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 when 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 an Aetna Medicare Plan (after becoming entitled to Medicare Part A and Part B), the Aetna Medicare Plan will be the primary insurance plan. If you are eligible for Medicare by reason of ESRD and Medicare is primary, you must enroll in Medicare A and B and submit proof of enrollment to the SHBP/SEHBP. 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 ensure that you 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 an Aetna Medicare Plan, regardless of whether they are Medicare-eligible due to age or disability, the Aetna Medicare Plan will be the primary insurance plan, not Medicare.

How to File a Claim If You Are Eligible for Medicare

For all Aetna Medicare Plan 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 ID card.

Members of an Aetna Medicare Plan 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 ID card) for processing under the Aetna Medicare Plan. Any questions can be directed to Aetna Medicare Plan 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.

CONTINUING COVERAGE

When Plan coverage would normally end, you or your covered family members may be able to continue coverage in certain circumstances. This section describes how you or your covered dependents may be able to temporarily continue coverage:

COBRA Continuation of Coverage

You and your dependents have the right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue medical coverage under certain circumstances (called “qualifying events”) when you would otherwise lose coverage. To do so, you must pay up to 102% of the full regular cost of coverage.

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. You cannot, however, 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.

The chart below lists the reasons that coverage could end for you or your covered family member. For each of those reasons, COBRA specifies the length of time that you may continue your Plan coverage.

Reason Coverage Ended (“COBRA Event”)	Maximum COBRA Continuation Period		
	You	Your Spouse	Your Child
You lose coverage because of reduced work hours	18 months	18 months	18 months
Your employment terminates for any reason, other than for gross misconduct	18 months	18 months	18 months
You or your covered family member becomes eligible for Social Security disability benefits when you lose coverage under the Plan	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce	N/A	36 months	36 months
Your child is no longer eligible	N/A	N/A	36 months

Continuation of Coverage Following Termination of Employment or Loss of Eligibility

You and your covered family members are eligible to continue coverage for up to 18 months if:

- You leave your employer for any reason other than gross misconduct; or
- You are no longer eligible because your working hours are reduced.

You may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue their own coverage.

If you or your dependent is disabled, as defined by the Social Security Administration, at the time of the qualifying event or becomes disabled within 60 days of the event, you may be entitled to an extra 11 months of coverage, for a total of 29 months. You must notify the Health Benfits Bureau of the Division of Pensions and Benefits of the disability within 60 days of the award or within 60 days of COBRA enrollment to receive the extension. Coverage may be continued for the disabled individual and for any family member for whom coverage is already being continued under COBRA, as well as for your newborn or newly adopted child who was added after the date COBRA continuation began. COBRA continuation of benefits will end on the first day of the month that begins more than 30 days after the final determination under Title II or XVI of the Social Security Act that the disabled individual is no longer disabled.

Continuation of Coverage Due to Other Qualifying Events

Your eligible dependents can continue coverage for up to 36 months if coverage would otherwise cease because:

- You die;
- You are divorced;
- You stop making contributions for a spouse from whom you are legally separated; or
- A covered child is no longer eligible under the Plan.

If one of the above events occurs while you or a covered dependent has already continued coverage due to the termination of your employment or your loss of eligibility, your dependent may extend coverage beyond the original 18-month continuation period, but for no more than a total of 36 months from the date coverage would originally have ended.

Applying for COBRA Continuation

Your Human Resources representative will give you information about how to continue COBRA coverage at the time you become eligible.

You must inform your employer of any status changes that would make your dependents eligible for COBRA coverage within 60 days of the later to occur of:

- The occurrence of the event; or
- The date coverage would terminate due to the event.

To ensure that there is no break in coverage, the election to continue coverage must be made within 60 days of:

- The date coverage would terminate due to the event; or
- The date your employer informs your dependents of their right to continue coverage; whichever happens later.

If you do not make your election within 60 days, you will lose your COBRA continuation rights.

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 is 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 nonparticipation 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.

Leave of Absence

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

When COBRA Continuation Coverage Ends

Continuation coverage will end on the earliest date that:

- Your employer drops out of the SHBP/SEHBP.
- The COBRA continuation period expires.
- You or your family members do not make the required contributions.
- You or your family members become covered under another group health plan.
- You or your family members become enrolled in Medicare. (Coverage could continue for those individuals not eligible for Medicare for up to 36 months from the original qualifying event, provided those family members otherwise remain eligible.)

Continuation for Total Disability

You may continue Plan coverage for up to 12 months if you are totally disabled when your Plan coverage ends. To be considered totally disabled:

- A covered employee must be:
  - — unable to work in his/her occupation, and
  - — not working for pay or profit.
- A covered dependent must be unable to engage in most of the normal daily activities of a healthy person of his/her age and sex.

This continued coverage ends after 12 months, or sooner if the covered person:

- Is no longer considered totally disabled; or
- Becomes covered by a plan with similar benefits.

COORDINATION WITH OTHER PLANS

Effect of Another Plan on This Plan's Benefits

If you have coverage under other group plans or receive payments for an illness or injury caused by another person, the benefits you receive from this Plan may be adjusted. This may reduce the benefits you receive from this Plan. The adjustment is known as coordination of benefits (COB).

Benefits available through other group plans and/or no-fault automobile coverage are coordinated with this Plan. "Other group plans" include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, regardless of whether that plan is insured.
- "No-fault" and traditional "fault" auto insurance, including medical payment coverage provided on other than a group basis, to the extent allowed by law.

If...	Then...
One plan has a COB provision and the other plan does not	The plan without a COB provision determines its benefits and pays first.
One plan covers you as a dependent and the other covers you as an employee or retiree	The plan that covers you as an employee or retiree determines its benefits and pays first.
You are eligible for Medicare and not actively working	These Medicare Secondary Payer rules apply: • The plan that covers you as a dependent of a working spouse determines its benefits and pays first. • Medicare pays second. • The plan that covers you as a retired employee pays third.
A child's parents are married or living together (whether or not married)	The plan of the parent whose birthday occurs earlier in the calendar year determines its benefits and pays first. If both parents have the same birthday, the plan that has covered the parent the longest determines its benefits and pays first. But if the other plan does not have this "parent birthday" rule, the other plan's COB rule applies.
A child's parents are separated or divorced, and a court decree assigns responsibility for the child's health expenses to one parent	The plan covering the child as the assigned parent's dependent determines its benefits and pays first.
A child's parents are separated or divorced with joint custody, and a court decree does not assign responsibility for the child's health expenses to either parent, or states that both parents are responsible for the child's health coverage	The "birthday rule" described above applies.
A child's parents are separated, divorced or not living together (whether or not they have ever been married), and there is no court decree assigning responsibilities for the child's health expenses to either parent	Benefits are determined and paid in this order: • The plan of the custodial parent pays, then • The plan of the spouse of the custodial parent pays, then • The plan of the non-custodial parent pays, then • The plan of the spouse of the non-custodial parent pays.

To find out if benefits under this Plan will be reduced, Aetna must first determine which plan pays benefits first. This chart shows which plan pays first

If...	Then...
You have coverage as an active employee or as the dependent of an active employee, and also have coverage as a retired or laid-off employee or the dependent of a retired or laid-off employee	The plan that covers you as an active employee or as the dependent of an active employee determines its benefits and pays first. This rule is ignored if the other plan does not contain the same rule.
You are covered under a federal or state right of continuation law (such as COBRA)	The plan other than the one that covers you under a right of continuation law will determine its benefits and pay first. This rule is ignored if the other plan does not contain the same rule.
The above rules do not establish an order of payment	The plan that has covered you for the longest time will determine its benefits and pay first.

When the other plan pays first, the benefits paid under this Plan are reduced as shown here:

- 100% of the expenses covered by one or both plans, minus
- Benefits paid by the other plan(s).

This prevents the sum of your benefits from being more than your actual expenses.

Aetna 2035 will provide its regular benefits in full when it is the primary plan. As a secondary plan, Aetna 2035 uses a non-duplication of benefits approach to COB. When Aetna 2035 is secondary to another health plan, Aetna 2035 will only provide reimbursement up to its normal liability if it had been primary. The secondary benefit payment under non-duplication COB is determined by calculating the Aetna 2035 normal liability then subtracting the other (primary) health plan payment, and paying the remaining amount, if any. If the primary health plan benefit is the same as or higher than the Aetna 2035 benefit, no secondary payment will be made.

Automobile-Related Injuries

The Plan is secondary to Personal Injury Protection (PIP) unless you choose the 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 the Plan as primary, this election may affect each of your family members differently.

When the Plan is primary to your PIP policy, benefits are paid in accordance with the terms, conditions and limits set forth by the medical plan option you have chosen. Your PIP policy would be a secondary payer to whom you would submit any bills unpaid by the 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 determined and paid its benefits. 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 the 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.

CLAIMS AND APPEALS

Claim Procedures

If you use an out-of-network provider, you must file a claim to be reimbursed for covered expenses. You must use a claim form to submit your claim. You can obtain a claim form from Aetna Member Services by calling the number on the back of your ID card, or by going online at ***www.aetna.com/statenj*** The form has instructions on how, when and where to file a claim.

File your claims promptly – the filing deadline is 90 days after the date you incur a covered expense. If, through no fault of your own, you are unable to meet that deadline, your claim will be accepted if you file it as soon as possible. Claims filed more than two years after the deadline will be accepted only if you had been legally incapacitated.

You may file claims and appeals yourself or through an "authorized representative," which is someone you authorize in writing to act on your behalf. In a case involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

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.**

Adverse benefit determinations are decisions Aetna makes that result in denial, reduction or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:
  - — it is not included in the list of covered benefits,
  - — it is specifically excluded,
  - — a Plan limitation has been reached, or
  - — it is not medically necessary.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown in the chart on the following page. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see *Appeals* for more information about appeals.

Type of Claim	Response Time
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.	As soon as possible but not later than 72 hours
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care.	15 calendar days
Concurrent care claim extension: a request to extend a previously approved course of treatment.	**Urgent care claim —** as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment. **Other claims —**15 calendar days
Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.	With enough advance notice to allow the Plan participant to appeal.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days

Extensions of Time Frames

The time periods described in the chart may be extended as follows:

- **For urgent care claims:** If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided.
- **For non-urgent pre-service and post service claims:** The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

If an extension is necessary because Aetna needs more information to process your post-service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you fail to provide the information, your claim will be denied.

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 circum-stances.	Treated like an urgent care claim or pre-service claim, depending on the circum-stances.
Post-service claim: a claim for a bene-fit 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 time-frame 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

If you or your covered dependent receives benefits as the result of an illness or injury caused by another party, the Plan has the right to be reimbursed for those benefits from any settlement or payment you receive from the person who caused the illness or injury. This process is called subrogation and reimbursement.

Definitions

The description of the subrogation and reimbursement process uses three terms that you need to understand. As used here, the term:

- "third party" means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as "third party injuries."
- "responsible party" includes any party responsible for payment of expenses associated with the care or treatment of third party injuries.
- "you" or "your" includes anyone on whose behalf this Plan pays or provides any benefits.

Right of Recovery

When the Plan pays benefits to you for expenses incurred due to third party injuries, then the Plan retains the right to repayment of the full cost of all benefits provided by the Plan on your behalf that are associated with the third party injuries. The Plan's rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of the third party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any:
  - — automobile policy,
  - — premises or homeowners' medical payments coverage, or
  - — premises or homeowners' insurance coverage; and
- Any other payments from a responsible party or another source intended to compensate you for injuries resulting from an accident or alleged negligence.

When You Accept Plan Benefits

By accepting benefits under this Plan, you specifically acknowledge the Plan's right of subrogation. When this Plan pays health care benefits for expenses incurred due to third party injuries, the Plan shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this Plan. The Plan may proceed against any party with or without your consent.

By accepting benefits under this Plan, you also specifically acknowledge the Plan's right of reimbursement. This right of reimbursement attaches to any payment received by you or your representative from any party responsible for paying for expenses associated with the care or treatment of third party injuries. By providing any benefit under this Plan, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this Plan. The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

By accepting benefits under this Plan, you or your representatives further agree to:

- Notify the Claim Administrator, Aetna, in writing, within 30 days of the time when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third party injuries sustained by you;
- Cooperate with Aetna and its designees and do whatever is necessary to secure the Plan's rights of subrogation and reimbursement under this Plan;
- Give the Plan a first-priority lien on any recovery, settlement, judgment or other source of compensation that may be had from any party to the extent of the full cost of all benefits associated with third party injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement, judgment or other source of compensation, any and all amounts due to the Plan as reimbursement for the full cost of all benefits associated with third party injuries paid by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement), unless otherwise agreed to by Aetna in writing;
- Do nothing to prejudice the Plan's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery that specifically attempts to reduce or exclude the full cost of all benefits paid by the Plan; and
- Serve as a constructive trustee for the benefits of this Plan over any settlement or recovery funds received as a result of third party injuries.

The Plan's recovery rights under this provision are first priority rights and the Plan is entitled to reimbursement even if such reimbursement results in a recovery to you that is insufficient to compensate you in whole or in part for your damages from a third party injury. The Plan may recover the full cost of all benefits paid by this Plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from the Plan's recovery, and the Plan and Claim Administrator are not required to pay or contribute to paying court costs or attorney fees for the attorney hired by you to pursue your claim or lawsuit against any third party without the prior express written consent of the Claim Administrator.

If You Do Not Follow the Process

In the event you or your representative fail to cooperate with the Plan and its Claim Administrator, you shall be responsible for all benefits paid by this Plan in addition to costs and attorney's fees incurred by the Plan and its Claim Administrator in obtaining repayment.

Recovery of Overpayment

If Aetna makes a benefit payment over the amount that you are entitled to under this Plan, Aetna has the right to:

- Require that the overpayment be returned on request; or
- Reduce any future benefit payment by the amount of the overpayment.

This right does not affect any other right of overpayment recovery Aetna may have.

Legal Action

No legal action can be brought to recover a benefit after three (3) years from the deadline for filing claims.

WHEN YOU NEED HELP

Resources

When you have questions or need more information, here are some of the resources available to you.

Resource	Situation	How to Contact
Client Services	Contact Client Services when: • You need to report a change in your name, address or telephone number	Phone: 1-609-292-7524 Online: *www.nj.gov/treasury/pensions/healthbenefits.shtml*
Aetna Member Services	Contact Member Services when: • You have questions about the Plan's benefits • You are required to obtain precertification for a service • You have a question about a claim	Phone: 1-877-782-8365 Online: *www.aetnastatenj.com*

Resource	Situation	How to Contact
Aetna Behavioral Health	Contact Aetna Behavioral Health when: • You are required to obtain precertification for a service • You need help finding a behavioral health provider	Phone: 1-800-424-5679 Online: ***www.aetnabehavioralhealth.com***
Aetna Navigator®	Use Aetna Navigator when you need: • Eligibility or claim status information • A replacement ID card • Copies of claim forms • Access to tools that help you manage your health care	Online: ***www.aetnastatenj.com***
Informed Health® Line	Call the Informed Health Line when you are looking for information about: • Medical procedures and treatment options • How to describe symptoms and ask the right questions when talking with your health care provider	Phone: 1-800-556-1555 TDD: 1-800-270-2386

Tools

Online Directory

DocFind® is Aetna's online provider **directory.** DocFind gives you the most recent information on the doctors, hospitals and other providers in the Aetna network. For each doctor or other health care provider, you can learn about his or her credentials and practice, including education, board certification, languages spoken, office location and hours, and parking and handicapped access. You can also provide feedback on a primary care physician (PCP), specialist or other medical professional after receiving services, using the online survey available at DocFind.

To access DocFind, go to ***www.aetnastatenj.com*** and follow the prompts.

Health Information Website

Aetna Navigator® is Aetna's benefits and health information website. Use Aetna Navigator as your online resource for personalized benefit and health information. You can take full advantage of this interactive website to complete a variety of self service transactions online. Once registered on Aetna Navigator, you'll have access to secure, personalized features, such as benefit and claim status, as well as specific health and wellness information.

With Aetna Navigator, you can:

- Print eligibility information;
- Request a replacement ID card;
- Download copies of claim forms;
- Check the status of a claim;
- Find benefit balances; and
- Contact Aetna Member Services.

Aetna Navigator also gives you access to useful tools that help you manage your health care:

- Cost of Care, a tool that allows you to research the costs of office visits, medical tests and selected medical procedures in your area.
- Hospital Comparison Tool, helps you compare area hospitals on measures that are important to your health.
- Aetna SmartSource℠, a search engine that scans Aetna's online resources and pulls together information that's specific to you – based on where you live, the plan you're enrolled in and your personal profile. Just enter a condition or symptom, and SmartSource will give you links to useful information, such as:
  - — a HealthMap® that lets you explore your health topic — including symptoms, treatment options, preventive steps and more — to help you see and plan for the road ahead.
  - — the names of local doctors in the Aetna network who specialize in treating the condition.
  - — estimated health care costs.
  - — Aetna programs and discounts that may help you manage your health care needs.
  - — health articles and tips.
- *Simple Steps To A Healthier Life®,* an online wellness program that offers information and self help tools for weight loss, stress management and fitness. When you visit the program's site, you can complete a Health Risk Assessment and receive a personalized action plan with recommended healthy living programs based on your personal health needs.
- *HSA Savings Calculator,* helps you figure out how your account can grow over time.
- *Personal Health Record (PHR),* gives you online access to personal information, including health alerts, a detailed health summary, and information and tools to help you make informed decisions about your health care. Your PHR combines your claim activity with personal information about your health history that you provide, creating a comprehensive health profile. In real time, the PHR will scan your health data and claims information against evidence and rules based clinical knowledge, and alert you and your doctor about possible urgent situations and care gaps. This information can help you and your doctor make the best decisions about health care events.

- *Health History Report,* an easy to understand summary of doctor visits, tests, treatments and other health related activity, based on claim activity. The information is organized by categories such as Names of Doctors and Medical Care. You can print your Health History Report and share it with your doctor.

You can access Aetna Navigator at ***www.aetnastatenj.com***

Informed Health® Line

Get the help and information you need to make good health care decisions – 24 hours a day, 7 days a week

– by calling Aetna's Informed Health Line. You can speak with a registered nurse at no cost by calling 1-800-556-1555.

Informed Health Line nurses are experienced in providing information on a variety of health topics. While they do not diagnose problems or give advice, they can:

- Help you understand your health issues and treatment choices;
- Help you improve communication with your doctor and give you good questions to ask;
- Tell you about the latest research on certain treatments and procedures, and explain their risks and benefits; and
- Save time and money, by showing you how to get the right care at the right time.

Informed Health Line also features an audio health library, a recorded collection of more than 2,000 health topics available in both English and Spanish.

Clinical Policy Bulletins

Aetna uses its Clinical Policy Bulletins (CPBs) as a resource when making benefit and claim decisions. CPBs are written on selected health care topics, such as new technologies and new treatment approaches and procedures. The CPBs describe whether Aetna has determined that a service or supply is medically **necessary,** based on clinical information.

You can find the CPBs at ***www.aetna.com*** The language of the CPBs is technical because it was developed for use in benefit administration, so you should print a copy and review it with your doctor if you have questions.

> **Keep in Mind**
>
> The CPBs define whether a service or supply is medically necessary, but they do not define whether the service or supply is covered by the Plan. This book, along with other Plan documents, describes what is covered and what is not covered by the Plan.

If you have questions about your coverage, you can contact Aetna Member Services at the toll-free telephone number on your ID card.

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. For more information, see *Precertification*.

The Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, this Plan covers the follow 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.

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 its 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.

GLOSSARY

A

Allowable Expense(s): Any medically necessary health care service or expense, part or all of which is covered in full or in part under any of the plans covering the Plan participant for whom the claim is made. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

Appeals: A process used by a Plan participant to request the health plan re-consider a previous authorization or claim decision.

B

Benefit: Payment received for covered services under the terms of the Plan.

Benefit Period: The maximum length of time for which benefits will be paid.

Brand Name Drug: A prescription drug that is protected by trademark registration.

C

Case Management: A process of identifying individuals at high risk for problems associated with complex health care needs and assessing opportunities to coordinate care to optimize the outcome.

Chemotherapy: Treatment of malignant disease by chemical or biological antineoplastic agents.

Claim: A request for payment of benefits for health care services provided to a Plan participant.

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

Coinsurance Limit: The coinsurance limit is the maximum that you must pay out of pocket for your **coinsurance** share each calendar year.

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.

Contract: A legal agreement between the State of New Jersey and Aetna Life Insurance Company that describes administrative responsibilities, benefits and limitations of the coverage.

Coordination of Benefits (COB): A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their benefits and provides the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Copayment (copay): The specified dollar amount or percentage required to be paid to an in-network provider by, or on behalf of, a Plan participant in connection with benefits.

Covered Benefits or Covered Services: Those medically necessary services and supplies that are covered in whole or in part under the Plan, subject to all the terms and conditions of the agreement between the State of New Jersey and Aetna Life Insurance Company.

Custodial Care: Any type of care where the primary purpose of the type of care provided is to attend to the Plan participant's daily living activities that do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Plan participant, and general maintenance care of colostomy or ileostomy.

D

Deductible: The amount of covered expenses that a Plan participant must pay each plan year before the Plan begins paying benefits.

Diagnostic Tests: Tests and procedures ordered by a provider to determine if a patient has a specific condition or disease based upon specific signs or symptoms demonstrated by the patient. Such diagnostic tools include, but are not limited to, radiology, ultrasound, nuclear medicine, and laboratory and pathology services or tests.

DocFind®: Aetna's electronic provider directory on the Aetna website. You can use DocFind to research in-network physicians, hospitals, dentists, pharmacists and other providers in your area.

Durable Medical Equipment (DME): Equipment that is:

- Made for and mainly used in the treatment of a disease or injury;
- Made to withstand prolonged use;
- Suited for use while not confined as an inpatient in the hospital;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

E

Effective Date: The date on which the coverage under a Plan participant's plan goes into effect at 12:01a.m.

Effective Treatment of Alcohol or Substance Abuse: This means a program of alcohol or substance abuse therapy that is prescribed and supervised by a **behavioral health provider** and either:

- Has a follow-up therapy program directed by a physician on at least a monthly basis; or
- Includes meetings at least once a month with organizations devoted to the treatment of alcohol or substance abuse.

  Note: Maintenance care (providing an alcohol- and/or drug-free environment) and detoxification are not considered "effective treatment."

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

- Includes a written treatment plan that is prescribed and supervised by a behavioral health provider;
- Includes follow-up treatment; and
- Is for a disorder that can be changed for the better.

Emergency (also called medical emergency): An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, 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 and her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Experimental or Investigational: A drug, device, procedure, or treatment will be determined to be experimental if:

- There is not sufficient outcome 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 or protocol(s) used by the treating facility or the protocol or 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 a Plan participant's particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of a Plan participant's particular condition; or
- It is provided or performed in special settings for research purposes.

Explanation of Benefits: An Explanation of Benefits form is given to Plan participants to explain how the payment amount for a health benefit claim was calculated. Among other things, the Explanation of Benefits may explain the claim appeal process.

H

Health Insurance Portability and Accountability Act (HIPAA): HIPAA is a federal law enacted in 1996. It was designated to improve availability and portability of health coverage by:

- Limiting exclusions for pre-existing conditions;
- Providing credit for prior health coverage;
- Allowing transmittal of the coverage information (i.e., covered family members and coverage period) to a new insurer;

- Providing new rights to allow individuals to enroll for health coverage when they lose their health coverage or have a new dependent;
- Prohibiting discrimination in enrollment/premiums; and
- Guaranteeing availability of health insurance coverage for small employers.

HIPAA's Administrative Simplification and Privacy (AS&P) Act final rules took effect in April, 2001. The purpose of these rules is to improve the efficiency of the health care system by standardizing the electronic exchange of health information and protecting the security and privacy of Plan participant-identifiable health information.

Home Health Care: Skilled nursing and other therapeutic services provided by a home health care agency in a home setting as an alternative to confinement in a hospital or skilled nursing facility.

Hospice Care: This is palliative and supportive care, either on an inpatient or outpatient basis, given to a terminally ill person and to his or her family. The focus of hospice programs is to enable terminally ill patients to remain, for as long as they can, in the familiar surroundings of their home.

Hospital: An institution rendering inpatient and outpatient services, accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation or specialty institution.

I

ID Card: Your Aetna ID card provides proof of your Aetna coverage. An ID card is sent to you after your enrollment is processed and accepted. Your Aetna ID card includes your Plan participant identification number, as well as the toll-free phone number to contact Aetna Member Services. If you need to request a new ID card, you may do so through Member Services.

Infertility:

- For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.
- For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

Infusion Therapy: Treatment accomplished by placing therapeutic agents into the vein, including intravenous feeding. Such therapy also includes enteral nutrition, which is the delivery of nutrients into the gastrointestinal tract by tube.

In-Network: Refers to services received from providers in the Aetna network.

In-Network Provider: Any physician, hospital, skilled nursing facility, or other individual or entity involved in the delivery of health care or ancillary services that contracts to provide covered services to Plan participants for a negotiated charge. Also called "preferred care provider."

Inpatient Care: Service provided after the patient is admitted to the hospital, skilled nursing facility or hospice. Inpatient care lasts 24 hours or more.

InteliHealth®: InteliHealth is Aetna's online health information site, offered in association with the Harvard Medical School. It is a provider of online consumer-based health, wellness and disease specific information. You can link to InteliHealth from Aetna's website (***www.aetna.com***).

M

Member Services: The Aetna Member Services department assists Plan participants with questions about plan benefits and exclusions and, if applicable to your plan, selecting or changing a primary care physician (PCP). Calling the toll-free number on your ID card will connect you with your plan's Aetna Member Services office. If you do not have your ID card yet, contact your employer's benefits office for the Member Services toll-free number.

Mental Disorder: A dysfunctional manifestation in the individual that may be physical, psychological or behavioral, and for which treatment is generally provided under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker.

N

Necessary, Medically Necessary, Medically Necessary Services or Medical Necessity: Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the *Your Medical Benefits* section of this booklet. 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 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; 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 above tests.

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 that 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;
- 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 his or her disease or injury could be diagnosed or treated safely and adequately on an outpatient basis; or
- 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.

Network: Physicians, hospitals and other health care providers who contract with Aetna to participate in health benefits plans.

O

Occupational Therapy: Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting and bathing.

Out-of-Network: The use of health care providers who have not contracted with Aetna to provide services.

Out-of-Network Provider: This term generally is used to mean providers who have not contracted with a health plan to provide services at negotiated fees, or an in-network provider who is furnishing services or supplies without a referral from the patient's PCP.

Out-of-Pocket Maximum: The out-of-pocket maximum is the maximum amount you must pay toward covered medical expenses in a calendar year. Once you reach this maximum, the Plan pays 100% of your remaining covered expenses for the rest of the year.

Outpatient Care: Care provided in a clinic, emergency room, hospital or non-hospital surgical facility ("surgicenter") without admission to the hospital or facility.

Outpatient Surgery: Surgical procedures performed that do not require an overnight stay in the hospital or ambulatory surgery facility. Such surgery can be performed in the hospital, a surgery center, or a physician's office.

P

PCP: See Primary Care Physician

Panel Review

A review of a level two appeal (see *Appeals*) by a panel of physicians and/or other providers selected by Aetna. Members of the panel:

- Must not have been involved in the adverse benefit determination at issue; and
- Must have access to consulting providers who are trained or who practice in the same specialty as would typically manage the case at issue. The consulting providers must not have been involved in the adverse benefit determination at issue.

Physical Therapy: Treatment involving physical movement to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb.

Plan Participant: An employee, retiree or dependent who is enrolled in and covered by a health care plan. Also called "enrollee."

Precertification (Also known as "authorization," "certification" or "prior authorization") : Certain healthcare services, such as hospitalization or outpatient surgery, require precertification by Aetna to ensure coverage for those services. When a Plan participant is to receive services requiring precertification through an in-network provider, this provider should obtain the necessary precertification for those services prior to treatment.

Prescription: An order by a prescriber for a prescription drug. If it is a verbal order, it must promptly be put in writing by the pharmacy.

Primary Care Physician (PCP): An in-network 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.

Prior Authorization: See Precertification

Prosthetic Devices: Device that replace all or a portion of a part of the human body. These devices are necessary because a part of the body is permanently damaged, is absent or is malfunctioning.

Provider: A licensed health care facility, program, agency, physician or health professional that delivers health care services.

R

RN: A registered nurse.

Radiation Therapy: Treatment of a disease by X-ray, radium, cobalt or high energy particle sources.

Recognized Charge: The recognized charge is the lower of:

- The provider's usual charge to provide that service or supply; or
- The charge Aetna determines to be appropriate, based on factors such as:
  - — The cost of supplying the same or a similar service or supply; and
  - — The way charges for the service or supply are made, billed or coded.

For non-facility charges: Aetna uses the 90th percentile of charges as reported in a database of charges that Aetna receives from a third party. Aetna may contribute information to that third party that is used in assembling the database.

For facility charges: Aetna uses the charge Aetna determines to be the usual charge level for the service in the geographic area where the service is furnished.

Aetna may reduce the recognized charge to address the appropriate billing of services, taking into account factors such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and necessary for the service;
- Whether follow-up care is included;
- Whether there are any other factors that modify or make the service unique; and
- Whether any services are part of or incidental to the primary service provided if the charge includes more than one claim line.

Aetna's reimbursement policies are based on:

- Aetna's review of policies developed for Medicare;
- Generally accepted standards of medical and dental practice; and

- The views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) that sets the rate Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

Respiratory Therapy: Treatment of illness or disease that is accomplished by introducing dry or moist gases into the lungs.

S

Second Opinion: The voluntary option or mandatory requirement to visit another physician or surgeon for an opinion regarding a diagnosis, course of treatment or having specific types of elective surgery performed.

Skilled Nursing Facility (SNF): An institution or a distinct part of an institution that is licensed or approved under state or local law, and that 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 the health plan 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 subspecialty.

Speech Therapy: Treatment for the correction of a speech impairment that resulted from birth, or from disease, injury or prior medical treatment.

T

Terminal Illness: An illness of a Plan participant, which has been diagnosed by a physician and for which the patient has a prognosis of 12 months or less to live.

U

Urgent Care: Services received for an unexpected illness or injury that is not life threatening but requires immediate outpatient medical care that cannot be postponed. An urgent medical condition requires prompt medical attention to avoid complications and unnecessary suffering or severe pain, such as a high fever.

W

Wellness Program: A health management program that incorporates the components of disease prevention, medical self-care, and health promotion. It utilizes proven health behavior techniques that focus on preventing illness and disability that respond positively to lifestyle related interventions.

All services, plans and benefits are subject to and governed by the terms (including exclusions and limitations) of the agreement between Aetna Life Insurance Company and the State of New Jersey. The information herein is believed accurate as of the date of publication and is subject to change without notice.