BENEFIT PLAN

Prepared Exclusively for
Millard Public Schools

Aetna Vision Preferred

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

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

*** This Booklet-Certificate describes only the benefits insured by Aetna. Please refer to the plan design summary provided by your employer for a description of any discount arrangements that may apply.**

Table of Contents

Schedule of Benefits ..... Issued with Your Booklet

Preface 1
Important Information Regarding Availability of Coverage
Coverage for You and Your Dependents 2
Health Expense Coverage 2
Treatment Outcomes of Covered Services
When Your Coverage Begins 3
Who Can Be Covered 3
Employees
Determining if You Are in an Eligible Class
Obtaining Coverage for Dependents
How and When to Enroll 4
Initial Enrollment in the Plan
Annual Enrollment
When Your Coverage Begins 5
Your Effective Date of Coverage
Your Dependent's Effective Date of Coverage
Requirements For Coverage 6
Your Aetna Vision Expense Plan 6
Getting Started: Common Terms 7
About the Aetna Vision Preferred Expense Plan 7
How Your Plan Works 8
Comprehensive Vision Expense Plan 9
What the Plan Covers
Limitations
Benefits for Vision Care Supplies After Your Coverage Terminates
Vision Plan Exclusions
When Coverage Ends 12
When Coverage Ends for Employees
When Coverage Ends for Dependents
Continuation of Coverage 13
Continuing Health Care Benefits
Continuing Coverage for Dependent Students on Medical Leave of Absence
Handicapped Dependent Children
COBRA Continuation of Coverage 15
Continuing Coverage through COBRA
Who Qualifies for COBRA
Disability May Increase Maximum Continuation to 29 Months
Determining Your Premium Payments for Continuation Coverage
When You Acquire a Dependent During a Continuation Period
When Your COBRA Continuation Coverage Ends
General Provisions 18
Type of Coverage 18
Physical Examinations, Autopsy, and Evaluations 18
Legal Action 18
Confidentiality 18
Additional Provisions 18
Assignments 19
Misstatements 19
Incontestability 19
Recovery of Overpayments 19
Health Coverage
Reporting of Claims 20
Notice of Claim
Claim Forms
Payment of Benefits 20
Records of Expenses 20
Contacting Aetna 21
Discount Programs 21
Discount Arrangements
Incentives 21
Appeals Procedure 21
External Review 26
Glossary * 28

*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface *(GR-9N-02-005-02 NE)*

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

Group Policyholder:	Millard Public Schools
Group Policy Number:	GP-737381
Effective Date:	January 1, 2016
Issue Date:	April 20, 2016
Booklet-Certificate Number:	2

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage *(GR-9N-02-020-01 NE)*

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an accident, **injury** or **illness** that occurred, began or existed while coverage was in effect.

Please refer to the sections, "*Termination of Coverage (Extension of Benefits)*" and "*Continuation of Coverage*" for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

Coverage for You and Your Dependents *(GR-9N-02-020-01 NE)*

Health Expense Coverage *(GR-9N-02-020-01 NE)*

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet-Certificate* for more information about your coverage.

Treatment Outcomes of Covered Services *(GR-9N-02-020-01 NE)*

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

When Your Coverage Begins

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Can Be Covered

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class", as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are an active part-time or full-time employee.

Eligibility Requirements for Employee Coverage:

1. is a full-time Active Employee of the Employer who is regularly and consistently scheduled to work at least thirty (30) hours per week and is on the regular payroll of the Employer for that work.

2. is a part-time Active Employee of the Employer. An Employee is considered to be part-time if he or she normally works at least twenty (20) hours per week and is on the regular payroll of the Employer for that work or actually works at least thirty (30) hours per week or more during the measurement period of August 1 through July 31.

Determining When You Become Eligible *(GR-9N-29-005-02)*

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents *(GR-9N 29-010 01 NE)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Dependent Children *(GR-9N-29-005-02)*

To be eligible, a dependent child must be:

- Under 26 years of age; or

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Any children placed with you for adoption (effective on the earlier of (i) the date of placement for the purpose of adoption, or (ii) the date of entry of an order granting the adoptive parent custody of the child for purposes of adoption);
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Important Reminder
Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll *(GR-9N-29-015-05-NE)*

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period.

When Your Coverage Begins *(GR-9N 29-025-02)*

Your Effective Date of Coverage

If you have met all the eligibility requirements, your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date you return your completed enrollment information; and
- Your application is received and approved in writing by **Aetna**; and
- The date your required contribution is received by **Aetna**.

Important Notice:
You must pay the required contribution in full.

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan by then.

Note: New dependents need to be reported to **Aetna** within 31 days because they may affect your contributions.

Requirements For Coverage *(GR-9N-09-005-01 NE)*

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:

   - Be included as a covered expense in this Booklet-Certificate;
   - Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet-Certificate for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.

2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply must be **medically necessary**. To meet this requirement, the medical services or supply must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:
   (a) In accordance with generally accepted standards of medical practice;
   (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
   (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
   (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Important Note
Not every service or supply that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

Your Aetna Vision Expense Plan *(GR-9N-22-005-02 NE)*

It is important that you have the information and useful resources to help you get the most out of your **Aetna** vision expense plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access services, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

The plan will pay for **covered expenses** up to the maximum benefits shown in this Booklet-Certificate. Coverage is subject to all the terms, policies and procedures outlined in this Booklet-Certificate. Not all vision care expenses are covered under the plan. Exclusions and limitations apply to certain services, supplies and expenses. Refer to the *What the Plan Covers*, *Exclusions* and *Schedule of Benefits* sections to determine what expenses are covered, excluded or limited.

Important Notes:

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your vision plan pays benefits only for services and supplies described in this Booklet-Certificate as **covered expenses** that are medically necessary.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive vision care services that are not or might not be covered benefits under this vision expense plan.
- Store this Booklet-Certificate in a safe place for future reference.

Getting Started: Common Terms *(GR-9N 22-010 01)*

You will find terms used throughout this Booklet-Certificate. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary*.

About the Aetna Vision Preferred Expense Plan

This **Aetna** comprehensive vision care insurance plan is designed to cover a wide range of vision services and supplies. Benefits are payable for each covered person as shown in the *Schedule of Benefits* for expenses incurred while this insurance is in force.

This plan provides access to covered benefits through a network of vision care **providers**. These network **physician**s and other vision care professionals have contracted with **Aetna** or an affiliate to provide vision care services and supplies to **Aetna** plan members at a fee called the **negotiated charge**.

Your **copayments** and **coinsurance** will usually be lower when you use participating **network providers** and facilities.

You also have the choice to access licensed **providers** outside the **network** for covered benefits. **Coinsurance** is usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan.

Some services and supplies may only be covered through **network providers**. Refer to the *Covered Benefits* section and the *Schedule of Benefits* to determine if any services are limited to network coverage only.

To better understand the choices that you have with your plan, please carefully review the following information. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **provider**. Either **Aetna** or any **network provider** may terminate the **provider** contract.

Ongoing Reviews

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by vision professionals to determine whether such services and supplies are covered benefits under this Booklet-Certificate. If **Aetna** determines that the recommended services or supplies are not covered benefits, you will be notified. You may appeal such determinations by contacting **Aetna** to seek a review of the determination. Please refer to the *Claim Procedures/Complaints and Appeals* section of this Booklet-Certificate.

How Your Plan Works

Accessing Network Providers and Benefits

- You may select a **network** vision care **provider** from the **Aetna Network Provider Directory** or by logging on to **Aetna**'s website at www.aetna.com. You can search **Aetna**'s online **directory**, DocFind, for names and locations of **physicians** and other vision care **providers** and facilities. You can change your vision care **provider** at any time.
- If a service you need is covered under the plan but not available from a **network provider**, please contact Member Services at the toll-free number on your ID card for assistance.
- You will not have to submit claims for services and supplies received from **network providers**. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** less any cost sharing required by you. You will be responsible for **coinsurance** and **copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **copayment**, **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits

Important Note:
You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- For certain types of services and supplies, you will be responsible for any **copayment** shown in the *Schedule of Benefits*.
- Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.
- You may be billed for any **copayment** or **coinsurance** amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits *(GR-9N-22-025-02 NE)*

You have the choice to directly access **physicians** or other vision care **providers** that do not participate with the **Aetna** provider network. You will still have coverage when you access **out-of-network providers** for covered benefits. You may have more out-of-pocket expenses.

- You select a **provider** for covered benefits.
- You may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to the **provider**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.
- If your **provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from a **provider**.

You will receive notification of what the plan has paid toward your medical expenses. It will indicate any amounts you owe towards your **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing for Out-of-Network Benefits

Important Note:
You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits.*

- Your **coinsurance** will be based on the **recognized charge**. If the health care **provider** you select charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefit* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.

Comprehensive Vision Expense Plan *(GR-9N-24-005-02 NE)*

What the Plan Covers

This plan covers charges for certain vision care exams and supplies described in this section. The plan limits coverage to a maximum benefit amount per Calendar Year. Refer to your *Schedule of Benefits* to determine the maximum benefits that apply to your plan, if any. You are responsible for any cost-sharing amounts, and any expenses you incur in excess of the benefit maximum, listed in the *Schedule of Benefits.*

Vision Exams

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- Routine eye exam: A complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam.

Benefits are payable up to the benefit maximum listed on your *Schedule of Benefits.* Refer to the *Schedule of Benefits* for frequency limits and maximums on exams.

Vision Supplies

Covered expenses include charges for prescription lenses and frames, or prescription contact lenses up to the benefit maximum, per benefit period listed in the *Schedule of Benefits.*

Prescription Lenses

Covered expenses include **prescription** lenses prescribed for the first time and new lenses required due to a change in **prescription** up to the benefit maximum, listed in your *Schedule of Benefits.*

- Charges for **prescription** contact lenses will be covered.

Benefits are payable up to the benefit maximum, per benefit period, listed in the *Schedule of Benefits.*

Covered expenses also include

- Aphakic lenses prescribed after cataract surgery; and
- Contact lenses required to correct visual acuity to 20/40 or better in the better eye if such correction cannot be made with conventional lenses.

Benefits for these lenses are payable up to the benefit maximums, per benefit period, listed on the *Schedule of Benefits.* You are responsible for any cost-sharing amounts listed in the *Schedule of Benefits.*

Frames
Covered expenses include expenses for frames if the lenses for them are covered under this section.

Eyeglass frames are covered when purchased with **prescription** lenses up to the benefit maximum, per benefit period, listed in your *Schedule of Benefits*.

Limitations
All **covered expenses** are subject to the vision expense exclusions in this Booklet-Certificate and are subject to the **copayments** or **coinsurance** listed in the *Schedule of Benefits*, if any.

Coverage is subject to the exclusions listed in the *Vision Plan Exclusions* section of this Booklet-Certificate.

Benefits for Vision Care Supplies After Your Coverage Terminates
If your coverage under the plan terminates while you are not totally disabled, the plan will cover expenses you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete eye exam was performed in the 30 days before your coverage ended, and the exam included refraction; and
- The exam resulted in lenses being prescribed for the first time, or new lenses ordered due to a change in **prescription**.

Coverage is subject to the benefit maximums described above and in your *Schedule of Benefits*.

Vision Plan Exclusions *(GR-9N-28-030-02-NE)*
Not every vision care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician**. The plan covers only those services and supplies that are included in the *What the Plan Covers* section. Charges made for the following are **not** covered. In addition, some services are specifically limited or excluded. This section describes expenses that are **not** covered or subject to special limitations.

Any charges in excess of the benefit, dollar, or supply limits stated in this Booklet-Certificate.

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

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

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

Any exams given during your **stay** in a **hospital** or other facility for medical care.

An eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses.

Drugs or medicines.

Experimental or **investigational** drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.

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

Miscellaneous charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;

- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service; or
  - Care while in the custody of a governmental authority.

For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.

For an eye exam which:

- Is required by an employer as a condition of employment; or
- An employer is required to provide under a labor agreement; or
- Is required by any law of a government.

Eye exams to diagnose or treat an illness or **injury**.

Acuity tests.

Prescription or over-the-counter drugs or medicines.

Special vision procedures, such as orthoptics, vision therapy or vision training.

Vision service or supply which does not meet professionally accepted standards.

Anti-reflective coatings.

Tinting of eyeglass lenses.

Duplicate or spare eyeglasses or lenses or frames for them.

Lenses and frames furnished or ordered because of an eye exam that was done before the date the person becomes covered.

Replacement of lost, stolen or broken **prescription** lenses or frames.

Special supplies such as nonprescription sunglasses and subnormal vision aids.

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

Services to treat errors of refraction.

Vision services that are covered in whole or in part:

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder; or
- Under any workers' compensation law or any other law of like purpose.

When Coverage Ends *(GR-9N-30-015-04)*

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, **Aetna** may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not actively at work due to **illness or injury**, your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

When Coverage Ends for Dependents *(GR-9N-30-015-02)*

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees.;
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage *(GR-9N-31-015-05)*

Continuing Health Care Benefits *(GR-9N-31-015-06)*

Continuation of Coverage After You Terminate Employment

If you involuntarily end your employment, you may continue any health coverage (except Dental Insurance) that was in force for you and your dependents as long as your termination was not due to:

- Misconduct linked with the job.
- A labor dispute.

In order for you and your dependents coverage to continue, you must:

- Request continued coverage within 10 days of the date your former employer notifies you that you are eligible for continuation (the request must include an agreement to pay up to 102% of the cost to the plan;) and
- Make payment for the coverage.

Coverage will end when the first of the following occurs:

- The end of a 6 month period after coverage would have otherwise ended.
- You become eligible for comparable benefits under any group plan.
- Any required contributions stop; or
- Health Expense coverage is discontinued for employees of your former Employer.

Your dependent's coverage will end when the first of the following occurs:

- He or she no longer meets the plan's definition of "dependent" or
- He or she becomes eligible for comparable benefits under this group plan.

Note: If any coverage being continued ceases, the person may apply for a personal policy in accordance with the Conversion Privilege. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

Continuing Coverage for Victims of Abuse

Continuation of Health Expense Coverage for Victims of Abuse apply only to the following dependents of employees of an Employer not subject to COBRA:

- Your dependent spouse who is a victim of abuse and whose dependent coverage terminates under this Plan due to divorce, legal separation, or the termination of your coverage under this Plan; and
- Your dependent child who is a victim of abuse and whose dependent coverage terminates due to your loss of custody or the termination of your coverage under this Plan.

A written request for such continuation must be made within 60 days of the date coverage terminates. The request must include:

- Evidence of abuse satisfactory to Aetna; and
- An agreement to pay up to 100% of the cost to this Plan.

Premium payments must be made.

Coverage will cease on the first to occur of:

- The date the person is eligible for similar benefits under any group plan; or
- The date the person becomes eligible for other coverage under the group contract; or

- The date the person fails to make any required contributions; or
- The date Health Expense Coverage under this Plan discontinues for employees of your Employer.

Coverage for a dependent child will stop when he or she no longer meet the plan's definition of "dependent".

Note: Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

Continuing Coverage for Dependent Students on Medical Leave of Absence *(GR-9N-31-015-01 NE)*

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious **illness** or **injury**, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. **Aetna** may require a written certification from the treating **physician** which states that the child is suffering from a serious **illness** or **injury** and that the resulting leave of absence (or change in full-time student status) is **medically necessary**.

Important Note
If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

Handicapped Dependent Children *(GR-9N-31-015-01 NE)*

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

COBRA Continuation of Coverage

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a "qualifying event" that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer's notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
Your marriage is annulled, you divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months

You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events.

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Premium Payments for Continuation Coverage

Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

Important Note
For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is neither disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.

- You or your covered dependents become covered under another group plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

General Provisions *(GR-9N-32-005-02-NE)*

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Physical Examinations, Autopsy, and Evaluations *(GR-9N-32-005-03-NE)*

Aetna will have the right and opportunity to have a **physician** or **dentist** of its choice examine any person who is requesting certification or benefits for new and ongoing claims. Multiple exams, evaluations, and functional capacity exams may be required during your disability for an ongoing claim. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Aetna, at its own expense, has the right and opportunity to examine the insured when and as often as reasonably required when a claim is pending and may make autopsy in case of death where it is not prohibited by law.

Legal Action *(GR-9N-32-005-03-NE)*

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

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of the plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna**'s Notice of Information Practices by calling **Aetna**'s toll-free Member Service telephone.

Additional Provisions

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *group policy*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

Assignments *(GR-9N-32-005-05-NE)*

Coverage may be assigned only with the written consent of **Aetna**. To the extent allowed by law, **Aetna** will not accept an assignment to an **out-of-network provider**, including but not limited to, an assignment of:

- The benefits due under this group insurance policy;
- The right to receive payments due under this group insurance policy; or
- Any claim you make for damages resulting from a breach or alleged breach, of the terms of this group insurance policy.

Misstatements *(GR-9N-32-005-05-NE)*

If any facts to age as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts to age will be used in determining whether coverage is or remains in force and its amount.

If a person's age has been misstated, all amounts payable under this policy will be such as the premiums paid would have purchased at the correct age.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by you, an eligible employee or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Recovery of Overpayments *(GR-9N-32-015-01 NE)*

Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

Reporting of Claims *(GR-9N 32-020-04-NE)*

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

Notice of Claim
Written notice of claim must be furnished to **Aetna**. It must give proof of the nature and extent of the loss. This must be done with 20 days after the occurrence or commencement of any covered loss, or as soon after that as is possible. Notice given, at **Aetna's** Home Office or to any agents, by or for a person making claim, with information sufficient to identify by person, shall be deemed to be notice of claim to **Aetna**.

Claim Forms
Aetna, upon receipt of notice of claim, will furnish forms as are usually furnished by it for filing proof of loss. If forms are not furnished within 15 days after giving notice of such claim, you will be deemed to have met the requirement for filing proof of loss upon submitting, within the time fixed for filing proof of loss, written proof covering the occurrence, character and extent of loss for which claim is made.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits *(GR-9N-32-025-02-NE)*

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

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

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

Any unpaid balance will be paid within 30 days of receipt by **Aetna** of the due written proof.

Aetna may pay up to $1,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses *(GR-9N-32-030-02)*

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

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

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Discount Programs *(GR-9N 32-045-01)*

Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

Incentives *(GR-9N 32-045-01)*

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment**, coinsurance, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

Appeals Procedure *(GR-9N 32-050-02 NE)*

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit, including a determination by Aetna or its designee utilization review agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefor denied, reduced, or terminated.

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

- Your eligibility for coverage.
- 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**.
- A decision that the service or supply is not **medically necessary**.

- A denial, reduction or termination or failure to provide or make payment that is based upon:
    - determination of an individual's eligibility to participate;
    - determination that a benefit is not a covered benefit;
    - pre-existing exclusion, source of injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
    - experimental, investigational or not **medically necessary** or appropriate.

An **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

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

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

Concurrent Care Claim Extension: A request to extend a course of treatment that was previously approved.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a course of treatment that was previously approved.

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

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

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Seriously jeopardize your life or health;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and appeals only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and **prescription drug** claims only, if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a **concurrent care claim**, to your **provider**.

Urgent Care Claims
Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than 72 hours after the claim is made.

If more information is needed to make an urgent claim decision, **Aetna** will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the **physician** to provide **Aetna** with the information.

Pre-Service Claims
Aetna will notify you of a **pre-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Post-Service Claims
Aetna will notify you of a **post-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Concurrent Care Claim Extension
Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **urgent care** as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination
Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

If you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints
If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must call or write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 15 calendar days of the receipt of the **complaint.** If a decision cannot be made within fifteen (15) business days due to circumstances beyond our control, an extension of up to fifteen (15) business days may be taken to issue a decision. A written notification of the extension will be sent to you within fifteen (15) business days of receiving the complaint. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

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

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

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

Send your written **appeal** to Member Services at the address shown on your ID Card.

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

You may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Level One Appeal

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

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 15 business days of receipt of the request for an **appeal**.

Voluntary Level Two Appeal -Group Health Claims

A Voluntary Level Two **Appeal** applies to all group health claims. If **Aetna** upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** or appropriateness of a covered benefit, or health care setting, or level of care, or rescission or effectiveness of a covered benefit is not met. (reasons, the **covered person** or their authorized representative has the right to file a Level Two **Appeal)**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **Appeal**.

A review of a Level Two **Appeal** of an **adverse benefit determination** of an **urgent care claim, a Pre-Service Claim, or a Post-Service Claim** shall be provided by Aetna personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for a Level Two **Appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two **Appeal**.

Post-Service Claims
Aetna shall issue a decision within 15 business days of receipt of the request for a Level Two **Appeal**.

Exhaustion of Process

At any time during the Appeal Procedure, you may:

- Contact the Nebraska Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint with the Nebraska Department of Insurance; or
- Establish any:
  - litigation directly with the health plan. You may contact Aetna at the address listed on the back of your ID card; or
  - administrative proceeding;

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

You may contact the Nebraska Department of Insurance at:

PO Box 82089
Lincoln, NE 68501-2089

Toll Free Hotline: (877) 564-7323
TDD: (800) 833-7352]

Under certain circumstances, you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

If **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or **appeal** straight to an **External Review**. Your claim or internal **appeal** will not go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.

External Review

You may receive an **adverse benefit determination** or **final adverse benefit determination**.

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

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

- You have received an **adverse benefit determination** notice by **Aetna,** and **Aetna** did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- You have received a **final adverse benefit determination** notice of the denial of the claim by **Aetna**.
- Your claim was denied because **Aetna** determined that the care was not **necessary** or appropriate or was **experimental or investigational**.
- You qualify for a faster review as explained below.
- As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which you are responsible exceeds $500.

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

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

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

A faster review is possible if your **physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:

- Seriously jeopardize your life or health; or
- Jeopardize your ability to regain maximum function; or
- If the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay;** or health service for which you received **emergency care**, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after **Aetna** receives the request.

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

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the ERO and for the cost of the external review except for dental, vision and hearing claims.

For more information about the Appeals Procedure or **External Review** processes, call the **Member Services** telephone number shown on your ID card.

Glossary

(GR-9N 34-005 01)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

A *(GR-9N-34-005-05)*

Aetna

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

C *(GR-9N 34-015 02)*

Coinsurance

Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as "plan **coinsurance**" and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Covered Expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet-Certificate.

D *(GR-9N 34-020 01)*

Deductible

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Directory

A listing of all **network providers** serving the class of employees to which you belong. The policyholder will give you a copy of this **directory**. **Network provider** information is available through **Aetna's** online provider **directory**, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this **directory**.

H *(GR-9N-34-040-02 NE)*

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and

- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

I *(GR-9N 34-045 02)*

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

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

M *(GR-9N-34-065-03 NE)*

Medically Necessary or Medical Necessity
These are health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must be:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
c) Not mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

N *(GR-9N 34-070 02)*

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

Network Provider
A health care provider who has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna's** consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Non-Occupational Illness
A **non-occupational illness** is an **illness** that does not:

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

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

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

Non-Occupational Injury
A **non-occupational injury** is an accidental bodily **injury** that does not:

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

O *(GR-9N-34-075-01 NE)*

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence
This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

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

Out-of-Network Provider
A health care provider who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

Physician
A duly licensed member of a medical profession who:

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

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Premium Progressive Lenses
These are multi-focal lenses that produce a gradual change in focus without lines or junctions and are the manufacturer's highest technology lenses.

Prescriber
Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug
A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

R *(GR-9N-34-090-01 NE)*

Recognized Charge *(GR-9N-34-090-01 NE)*

The **covered expense** is only that part of a charge which is the **recognized charge**.

As to vision expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  - the Prevailing Charge Rate;
  - for the Geographic Area where the service is furnished.

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service 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;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical community or which is otherwise consistent with **physician** recommendations; and the views of **physicians** practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates: These are rates reported in the Prevailing Health Care Charges System (PHCS) database.

Important Note
Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

Additional Information
Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

S *(GR-9N 34-095-05)*

Standard Progressive Lenses
These are multi-focal lenses that produce a gradual change in focus without lines or junctions but are not the manufacturer's highest technology lenses.

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Confidentiality Notice

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

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

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

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

Additional Information Provided by

Millard Public Schools

Name of Plan:
Millard Public Schools Employee Benefit Plan

Employer Identification Number:
47-60002642

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Millard Public Schools
5606 South 147th Street
Omaha, Nebraska 68137

Agent For Service of Legal Process:
Millard Public Schools
5606 South 147th Street
Omaha, Nebraska 68137

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the Plan Administrator.

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

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

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

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

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

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

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

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

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

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

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

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.