

AETNA SELF-FUNDED HMO

PLAN DETAILS

2017 PLAN YEAR

TABLE OF CONTENTS

HOW TO USE YOUR SUMMARY PLAN DESCRIPTION (SPD) 1

HOW THE PLAN WORKS 3

 The Primary Care Physician 3

 Primary and Preventive Care 3

 Specialty and Facility Care 3

 Provider Information 5

 Your ID Card 5

 Eligibility..... 5

 Pre-Determination of Medical Benefits 5

SCHEDULE OF BENEFITS 7

YOUR BENEFITS 12

 Primary and Preventive Care 12

 Specialty and Outpatient Care 13

 Inpatient Care in A Hospital, Skilled Nursing Facility Or Hospice..... 16

 Maternity 18

 Autism Spectrum Disorder 18

 Diabetic Equipment, Supplies, Self-Management Education and Training Services 19

 Behavioral Health 20

 Mental Health Treatment 20

 Treatment of Alcohol and Drug Abuse 21

 Prescription Drugs 21

 Prescription Drug Out-Of-Pocket Maximum 22

 Home Delivery Drugs 22

 Specialty Medications 23

 Emergency Prescriptions..... 23

 Covered Drugs 24

 Prescription Drug Exclusions And Limitations..... 25

EXCLUSIONS AND LIMITATIONS..... 28

 Exclusions..... 28

 Limitations..... 33

IN CASE OF MEDICAL EMERGENCY 34

 Guidelines..... 34

 Follow-Up Care After Emergencies 35

 Urgent Care 35

 What to Do Outside Your Aetna Service Area..... 36

SPECIAL PROGRAMS 37

 Aetna Vision Discount Program 37

Women’s Healthcare 37

 Direct Access for OB/GYN Visits 37

 Confidential Genetic Testing For Breast and Ovarian Cancers 37

 Infertility Case Management and Education..... 37

WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN..... 38

COORDINATION OF BENEFITS AND CLAIMS..... 39

 Coordination of Benefits..... 39

 Subrogation 40

 What You Need To Know 41

 Recovery of Third Party Payments 41

 Claim Procedures 42

WHEN COVERAGE ENDS 44

MEMBER SERVICES 45

 Internet Access 45

YOUR RIGHTS AND RESPONSIBILITIES 47

 As A Plan Participant, You Have A Right To: 47

 As A Plan Participant, You Have The Responsibility To: 48

NOTICE OF PRIVACY PRACTICES 49

GLOSSARY 50

HOW TO USE YOUR SUMMARY PLAN DESCRIPTION (SPD)

If you are enrolled in the Aetna self-funded HMO option available under the Salaried Active Medical Plan or Salaried Retiree Medical Plan, this Self-Funded HMO Supplement, when taken together with the following other documents:

- For the Active Medical Plan, the General/Administrative Information Plan Details and Active Medical Plan Details (see the box below for access instructions)
- For the Salaried Retiree Medical Plan, the Salaried Retiree Medical Plan Description

is considered your total Summary Plan Description for that Plan, as required by the Employee Retirement Income Security Act of 1974 (ERISA). Please read these documents carefully and refer to them when you need information about how the Plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. They are also an excellent source for learning about many of the special programs available to you as a Plan participant. If there are any conflicts between this Plan Details Supplement and the General/Administrative Information and Active Medical Plan Details or the Salaried Retiree Medical Plan SPD, this Plan Details Supplement will prevail.

ACCESSING PLAN DETAILS/SUMMARY PLAN DESCRIPTIONS (SPDs) AND FORMS

To access Plan Details/SPDs for descriptions of particular benefit plans, or forms and certain other benefit materials, visit the For Your Benefit website where you can access Your Benefits Resources™ (YBR) at www.resources.hewitt.com/jnjbsc.

Alternatively, you can submit a request through YBR to have copies of Plan Details/SPDs sent to your mailing address on file. You may also call the Benefit Service Center at 1-800-565-0122 (if calling from outside the U.S. or Canada: 1-847-883-0796; TDD: please call your local relay service). You will receive the materials requested within 30 days.

If you cannot find the answer to your question(s) in the supplement, call the Member Services toll-free number on your ID card. A trained representative will be happy to help you. For more information, go to the [Member Services](#) section on Page 45 of this Plan Details Supplement.

Your Health Maintenance Organization (HMO)* benefits program is self-funded by Johnson & Johnson and administered by Aetna Life Insurance Company (Aetna). The HMO's prescription drug benefit is administered by Express Scripts.

** As used in this supplement, "HMO" refers to HMO-type benefits that are self-funded by Johnson & Johnson.*

You will find terms starting with capital letters throughout this supplement. To help you understand your benefits, most of these terms are defined in the [Glossary](#) section on Page 50 of this supplement or in the "Glossary of Terms" in the Active Medical Plan Details (or for retirees, the Salaried Retiree Medical Plan Description) (both are available on YBR).

TIPS FOR NEW PLAN PARTICIPANTS

- Keep this supplement and the other
- SPD sections (or for retirees, the Salaried Retiree Medical Plan Description) where you can easily refer to them.
- Keep your ID cards in your wallet.
- Post your Primary Care Physician's name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24-hours a day. See the In Case of Medical Emergency section on Page 34 for emergency care guidelines.

HOW THE PLAN WORKS

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

Each participant in the Plan must select a Primary Care Physician (PCP) when he or she enrolls. Your PCP serves as your guide to care in today's complex medical system and will coordinate and monitor your overall care.

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when Medically Necessary, your PCP will refer you to other doctors or facilities for treatment. The referral is important because it is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment. Except for PCP, direct access and emergency services and certain other services described in the supplement, you must have a prior written or electronic referral from your PCP to receive coverage for all services and any necessary follow-up treatment.

Primary and Preventive Care

Your PCP can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP, including all Grade A & B recommendations per the US Preventive Services Task Force under the Patient Protection and Affordable Care Act (PPACA). You may also obtain routine vision exams and gynecological exams from participating providers without a referral from your PCP. You are responsible for any Copay shown in the [Schedule Of Benefits](#) section on Page 7.

Specialty and Facility Care

Your PCP may refer you to a specialist or facility for treatment or for covered preventive care services when Medically Necessary. Except for those benefits described in this Plan Details Supplement as direct access benefits and emergency care, you must have a prior written or electronic referral from your PCP in order to receive coverage for any services the specialist or facility provides.

When your PCP refers you to a participating specialist or facility for covered services, you will be responsible for the Copay shown in the [Schedule Of Benefits](#) section on Page 7.

To avoid costly and unnecessary bills, follow these steps:

- **Consult your PCP first** when you need routine medical care. If your PCP deems it Medically Necessary, you will get a written or electronic referral to a participating specialist or facility. Referrals are valid for one year, as long as you remain an eligible participant in the Plan. When a referral is issued, the first visit must be used within 90 days from when it was issued for the referral to be valid. The remaining visits can be used within a year from the original issue date. For direct access benefits, you may contact the participating provider directly without a referral.
- Certain services require **both** a referral from your PCP **and** prior authorization from Aetna. You and your PCP are responsible for obtaining prior authorization.
- **Review the referral** with your PCP. Understand what specialist services are being recommended and why.
- Present the referral to the participating provider. Except for direct access benefits, any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services.**
- If it is not an emergency and you go to a doctor or facility without your PCP's prior written or electronic referral, you must pay the bill yourself **and no amount will be covered.**
- Your PCP may refer you to a non-participating provider for covered services that are not available within the network. Services from non-participating providers require prior approval by Aetna in addition to a special non-participating referral from your PCP. When properly authorized, these services are covered after the applicable Copay.

Remember: You cannot request referrals after you visit a specialist or Hospital. Therefore, to receive coverage, **(you must contact your PCP and get authorization from Aetna (when applicable) before seeking specialty or Hospital care.)**

Some PCPs are affiliated with integrated delivery systems (IDS) or other provider groups (such as Independent Practice Associations and Physician-Hospital Associations). If your PCP participates in such an arrangement, you will usually be referred to specialists and Hospitals within that system or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may ask to have services provided by non-affiliated Physicians or facilities. Services provided by non-affiliated providers may require prior authorization from Aetna and/or the IDS or other provider group. Check with your PCP or call the Member Services number that appears on your ID card to find out if prior authorization is necessary.

Provider Information

You may obtain a listing of network providers by calling the toll-free Member Services number on your ID card or by logging on to www.aetna.com.

Your ID Card

When you join the Plan, you will receive an Aetna identification card listing each covered family member. Your ID card lists the telephone number of each family member's PCP. If a family member changes his or her PCP, you will automatically receive a new card displaying the change.

Always carry your ID card with you. It identifies you as a Plan participant when you receive services from participating providers or when you receive emergency services at non-participating facilities. If your card is lost or stolen, please notify Aetna immediately.

You will receive an Express Scripts identification card for your prescription drug benefit. When you obtain a prescription at a participating pharmacy, remember to present your Express Scripts ID card. If your card is lost or stolen, please notify Express Scripts immediately.

Eligibility

Please refer to the General/Administrative Information Plan Details (or for retirees, the Salaried Retiree Medical Plan Description) (both are available on YBR) for information on eligibility for you and your dependents.

Pre-Determination of Medical Benefits

You may submit a Pre-Determination of Medical Benefits form to the Service Administrator or call Member Services to find out if a service or supply will be covered and what portion of a service or supply will be covered before the service is performed. You can request forms by calling Member Services at the phone number on your ID card or you can print them from YBR.

The form requires the following information: name of Provider performing the service, place of service (e.g., Hospital, Physician's office) including ZIP code, procedure and code, scheduled or approximate date of service and charge for service. Medical information supporting the need for the service or supply should be submitted with the form.

You will receive a written pre-determination of your benefits. It will show you what benefits will be covered under the Plan based on the information provided to the Service Administrator. This is only an estimate. Actual benefits will depend on a number of factors, including your or your Dependents' eligibility at the time services are provided, Plan limitations and any other medical coverage

you have. The final decision regarding the care you receive is up to you and your Physician.

SCHEDULE OF BENEFITS

The following chart provides an overview of some of the different types of medical expenses and how they are paid when you receive Medically Necessary In-Network care. All non-emergency specialty and Hospital services require a prior referral from your PCP, unless the service is a "direct access" service, where noted in this Plan Details Supplement.

Please refer to the [Your Benefits](#) section on Page 12 of this Plan Details Supplement for a more complete explanation of the specific services covered.

CATEGORIES	2017 AETNA HMO
Acupuncture Expenses	100%, no Copay (in lieu of anesthesia)
Aids Testing	100%, no Copay
Allergy Injections	100%, \$20 PCP Copay; \$40 Specialist Copay
Ambulance	100%, no Copay
Anesthesia	100%, no Copay
Anesthesiologist	100%, no Copay
Annual Deductible	N/A
Annual Out-of-Pocket Maximum for Mental Health/Substance Abuse Treatment	Expenses included in the Medical Annual Out-of-Pocket Maximum below
Annual Out-of-Pocket Maximum (Medical)	You Only: \$3,000 You + Spouse/Partner: \$4,500 You + Child(ren): \$4,500 You + Family: \$6,000
Annual Out-of-Pocket Maximum (Prescription Drug)	You Only: \$2,000 You + Spouse/Partner: \$4,000 You + Your Child(ren): \$4,000 You + Family: \$4,000
Artificial Insemination	100%, \$40 Copay, up to six cycles per lifetime, and infertility surgery (diagnostic or therapeutic)
Bariatric Surgery	Inpatient: 100%, \$500 Copay per Admission Outpatient: 100%, \$50 per visit Copay

AETNA SELF-FUNDED HMO
SCHEDULE OF BENEFITS

CATEGORIES	2017 AETNA HMO
Blood and Blood Plasma/Autologous (self-donated blood)	100%, no Copay
Breast Exam	100%, no Copay when provided as part of a routine exam
Breastfeeding Support, Supplies and Counseling	100%, no Copay
Cardiac Therapy (Rehabilitative)	100%, \$40 Copay
Cancer Clinical Trials	100%, no Copay, for routine patient services
Chemotherapy	100%, no Copay
Child Care Exams (Well-Child Care)	100%, no Copay
Chiropractic	100%, \$40 Copay (maximum of 20 non-maintenance visits per calendar year)
Cognitive Therapy	100%, \$20 Copay (maximum of 60 days per calendar year for occupational, physical, speech and cognitive therapy combined)
Colonoscopy/Sigmoidoscopy	100%, no Copay (routine); If non-routine, \$50 outpatient surgery Copay applies; (colonoscopy - 1 per 10 years for ages 50+ and sigmoidoscopy - 1 per 5 years for ages 50+)
Contraceptives	Participating Pharmacies: You pay \$25 Copay per prescription for up to 30-day supply, \$50 copay per prescription for 31-60 day supply, \$75 per prescription for 61-90 day supply. Home Delivery: You pay \$60 Copay for up to 90-day supply. Injectable contraceptives are covered. Plan pays 100% for generic contraceptives and drugs manufactured/marketed by the Johnson & Johnson Family of Companies (pharmacy and home delivery).
Contraceptive Methods and Counseling	100%, no Copay
Doctor and Surgeon Services in a Hospital, Extended Care Facility or Other Covered Inpatient Facility (Includes assistant and co-surgeon fees)	100%, no Copay (Included in \$500 Inpatient Copay)
Doctor Services for Outpatient Surgery	100%, Appropriate office visit Copay applies if performed in an office setting

AETNA SELF-FUNDED HMO**SCHEDULE OF BENEFITS**

CATEGORIES	2017 AETNA HMO
Doctors' Office Visits—Primary and Specialty Care	100%, \$20 PCP Copay; \$40 Specialist Copay
Durable Medical Equipment	100%, no Copay
Emergency Room Care	100% after \$75 Copay per visit; No Copay if admitted from emergency room. Non-Emergency use of the Emergency Room is not covered.
Extended Care Facility/Rehab Facility	100%, \$500 Copay per Admission (Copay waived if transferred from inpatient confinement)
Eye Exams—Routine	100%, no Copay (one per calendar year; no referral needed unless a diagnosis results from the exam, in which case a referral must be obtained within 14 calendar days of the date of the exam)
Fertility Assistance with respect to Artificial Insemination and Ovulation Induction	100%, \$20 PCP Copay; \$40 Specialist Copay (Injectibles for Infertility are not covered. Clomid is covered under the Pharmacy Plan.)
Hearing Exams—Routine	100%, no Copay (one per calendar year)
Hemodialysis	100%, no Copay
Home Healthcare Visits	100%, no Copay
Hospice Care	100%, no Copay
Hospital Ancillary Services	100%, no Copay
Hospital Room and Board (Semi-private)	100% after \$500 Inpatient Copay per admission; if readmitted for the same condition within 30 days, then no Copay for readmission
Immunizations—Adult	100%, no Copay
Immunizations—Pediatric	100%, no Copay
Lab and X-ray—Diagnostic (Outpatient)	100%, \$20 PCP Copay; \$40 Specialist Copay if office visit is billed
Mammograms	100%, no Copay routine; Copay may apply non-routine
Maternity Care Office Visits	100% after \$20 PCP Copay; \$40 Specialist Copay (for first prenatal visit only; no Copay for routine maternity care office visits thereafter)
Mental Health—Individual Outpatient Care	100%, \$20 Copay

AETNA SELF-FUNDED HMO

SCHEDULE OF BENEFITS

CATEGORIES	2017 AETNA HMO
Mental Health—Inpatient Care and Approved Structured Outpatient Treatment Programs (In lieu of Inpatient Care)	100% after \$500 Inpatient Copay per admission
Occupational Therapy (Rehabilitative)	100%, \$20 Copay (maximum of 60 days per calendar year for occupational, physical, speech and cognitive therapy combined)
Oxygen	100%, no Copay
Pap Smears	100%, no Copay
Pelvic Exams	100%, no Copay (one per calendar year)
Physical Exams—Adult Routine	100%, no Copay (limit of one exam per calendar year)
Physical Therapy (Rehabilitative)	100%, \$20 Copay (maximum of 60 days per calendar year for occupational, physical, speech and cognitive therapy combined)
Pre-Admission Testing	100%, no Copay
Prescription Drug Benefits (Including injectable contraceptives, oral contraceptives and diaphragms)	Participating Pharmacies: You pay \$25 Copay per prescription for up to 30-day supply, \$50 copay per prescription for 31-60 day supply, \$75 per prescription for 61-90 day supply. Home Delivery: You pay \$60 Copay for up to 90-day supply. Certain injectable drugs are covered, including injectable contraceptives and insulin. Plan pays 100% for female generic contraceptives, approved tobacco cessation over-the-counter and prescription medications and drugs manufactured/ marketed by the Johnson & Johnson Family of Companies (pharmacy and home delivery).
Private Duty Nursing	Not covered
Prosthetics	100%, no Copay
Radiation Therapy	100%, no Copay
Second and Third Physician Opinions	100%, \$20 PCP Copay; \$40 Specialist Copay
Speech Therapy	100%, \$20 Copay (maximum of 60 days per calendar year for occupational, physical, speech and cognitive therapy combined)

AETNA SELF-FUNDED HMO**SCHEDULE OF BENEFITS**

CATEGORIES	2017 AETNA HMO
Substance Abuse—Inpatient Care and Approved Structured Outpatient Treatment Programs (In lieu of Inpatient Care)	100% after \$500 Inpatient Copay per admission
Substance Abuse—Individual Outpatient Care	100%, \$20 Copay
Surgical Care Facility—Ambulatory	100%, \$50 Copay
Urgent Care Center	100%, \$40 Copay
Walk-in Clinic	100%, \$20 Copay

Note: The Plan covers all Grade A & B recommendations at 100% per the US Preventive Services Task Force under the Patient Protection and Affordable Care Act (PPACA), however, an office visit Copay may apply.

YOUR BENEFITS

Although a specific service may be listed as a covered benefit, it may not be covered unless it is Medically Necessary for the prevention, diagnosis or treatment of your illness or condition. Refer to the [Glossary](#) section on Page 50 for the definition of "Medically Necessary."

Certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval.

Primary and Preventive Care

One of the Plan's goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan (after any applicable Copay) if provided by your PCP or on referral from your PCP. The Plan covers the following primary and preventive care services:

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations.
- Well-child care from birth, including immunizations and booster doses, as recommended by your PCP.
- Health education counseling and information.
- Routine annual gynecological examination and Pap smear performed by your PCP or gynecologist (no referral required).
- Routine immunizations (except those required for travel or work).
- Periodic eye examinations. You may visit a participating provider without a referral for one routine eye exam per calendar year.
- Routine hearing screenings performed by your PCP as part of a routine physical examination.
- Injections, including routine allergy desensitization injections.

Routine Cancer Screenings:

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Routine annual mammogram for female Plan participants age 40 or over;
 - Annual screening is covered for younger women who are judged to be at high risk by their PCP.

Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as Medically Necessary

- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by a Physician;
- Fecal occult blood tests;
- Digital rectal exams;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE);
- Colonoscopies (removal of polyps performed during a screening procedure is a covered expense); and
- Lung cancer screening.

These benefits will be subject to any age; family history; and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services. You must have a valid prior written or electronic referral from your PCP in order to receive coverage for any non-emergency services the specialist or facility provides.

The Plan covers:

- Acupuncture and acupuncture therapy, when performed by a participating Physician as a form of anesthesia in connection with covered surgery. In addition, the Plan covers acupuncture (manual or electroacupuncture) when medically necessary for the following indications:
 - Postoperative and chemotherapy-induced nausea and vomiting;
 - Nausea of pregnancy;
 - Postoperative dental pain;
 - Temporomandibular disorder (TMD)
 - Migraine headache;
 - Pain from osteoarthritis of the knee or hip (adjunctive therapy); or
 - Chronic low back pain (Maintenance treatment, where the patient's symptoms are neither regressing or improving, is not considered Medically Necessary.)
- Participating specialist office visits.
- Participating specialist consultations, including second opinions.

- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. Certain outpatient surgery must be approved in advance by Aetna. For a listing of surgeries requiring approval, please visit www.aetna.com. From the Home page, click "Health Care Professionals," then "Policies and Guidelines," and then "Clinical Policy Bulletins." You may also contact Member Services at the number on your ID card.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Charges made for routine patient services associated with qualifying cancer clinical trials approved by the National Cancer Institute and/or the Commission on Cancer will be paid for at 100%. These charges will not require a Copay. The coverage will include phases I – IV for approved trials as outlined by the National Cancer Institute and/or the Commission on Cancer. Routine patient services do not include, and reimbursement will not be provided for, services or supplies which, in the absence of private healthcare coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant. Participants covered under this Plan have access to qualifying cancer treatment at Commission on Cancer-approved facilities and/or National Cancer Institute-approved cancer centers. To receive these benefits, call Member Services at the phone number on your ID card and inform them of your or your covered Dependent's participation in a qualifying cancer clinical trial.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling) and physical therapy for treatment of non-chronic and chronic conditions and acute illness or injury, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure. Physical therapy does not include educational training.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service—24 hours a day, 7 days a week (see the [In Case of Medical Emergency](#) section on Page 34).

- Home health services provided by a participating home healthcare agency, including:
 - Skilled nursing services provided or supervised by a Registered Nurse;
 - Services of a home health aide for skilled care; and
 - Medical social services provided or supervised by a qualified Physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.
- Outpatient hospice services for a Plan participant who is terminally ill, including:
 - Counseling and emotional support;
 - Home visits by nurses and social workers;
 - Respite care is covered for 15 days per lifetime;
 - Pain management and symptom control; or
 - Instruction and supervision of a family member.

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

- Funeral arrangements, pastoral counseling or financial or legal counseling; or
- Homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
- Oral Surgery: Hospital charges, room and board and necessary services and supplies if it is Medically Necessary to hospitalize you (or your covered Dependent) for oral surgery.
- Reconstructive breast surgery following a mastectomy, including:
 - Reconstruction of the breast on which the mastectomy is performed, including areola reconstruction and the insertion of a breast implant;
 - Surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed; and
 - Physical therapy to treat the complications of the mastectomy, including lymphedema.
- Infertility services to diagnose and treat the underlying medical cause of infertility. You may obtain the following basic infertility services from a participating gynecologist or infertility specialist without a referral from your PCP:
 - Initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory;
 - Evaluation of ovulatory function;
 - Ultrasound of ovaries at an appropriate participating radiology facility;

- Postcoital test;
- Hysterosalpingogram; and

Endometrial biopsy. Semen analysis at an appropriate participating laboratory is covered for male Plan participants; a referral from your PCP is necessary.

If you do not conceive after receiving the above infertility services, or if the diagnosis suggests that there is no reasonable chance of pregnancy as a result of the above services, you are eligible to receive the following comprehensive services through a participating infertility specialist when preauthorized through and coordinated by the Aetna Infertility Unit:

- Ovulation induction cycles (blood work and ultrasounds), subject to a lifetime maximum of six cycles;
- Laparoscopy;
- Artificial insemination, subject to a lifetime maximum of six attempts; and
- Infertility surgery (diagnostic or therapeutic).

Assisted Reproductive Technology (ART) procedures are excluded.

- Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist. Maintenance care is not covered.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Prosthetics require preauthorization by Aetna.
- Durable Medical Equipment (DME), prescribed by a Physician for the treatment of an illness or injury, and preauthorized by Aetna.

The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:

- They are needed due to a change in your physical condition; or
- It is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

The request for any type of DME must be coordinated by the treating Physician.

Inpatient Care in A Hospital, Skilled Nursing Facility Or Hospice

If you are hospitalized by a participating PCP or specialist (with prior referral, except in emergencies), you receive the benefits listed below. See the [Behavioral](#)

[Health](#) section on Page 20 for inpatient mental health and substance abuse benefits.

The Plan covers:

- Confinement in semi-private accommodations (or private room when Medically Necessary) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Intensive or special care facilities.
- Visits by your PCP while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating Hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations.
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
 - Cardiac rehabilitation; and
 - Pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic resonance imaging.
- Non-experimental, non-investigational transplants. All transplants must be ordered by your PCP and participating specialist and approved in advance by Aetna. Transplants must be performed in Hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered

only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

- Surgery to change the sex of a person diagnosed with gender identity disorder in accordance with the World Professional Association for Transgender Health (WPATH) medical necessity guidelines. Precertification must be obtained from Aetna.

Maternity

The Plan covers Physician and Hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Health Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a Cesarean section). However, your provider may—after consulting with you—discharge you earlier than 48 hours after a vaginal delivery (96 hours following a Cesarean section).

You do not need a referral from your PCP for visits to your participating obstetrician. A list of participating obstetricians can be found by logging on to www.aetna.com. You may also call the Member Services number on your ID card.

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

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

Autism Spectrum Disorder

Covered expenses include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy and Applied Behavior Analysis) of Autism Spectrum Disorder when ordered by a **physician**, licensed psychologist, or licensed clinical social worker, as part of a Treatment Plan; and the covered child is diagnosed with Autism Spectrum Disorder.

Applied Behavior Analysis (ABA) is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association

Any child diagnosed with an autism spectrum disorder (ASD) is eligible. The following requirements apply:

For ABA:

- Precertification is required prior to services being rendered.
- Ongoing reviews for medical necessity take place at specific intervals throughout the child's treatment (intervals vary based on the child's needs and the target behaviors that are being addressed through therapy).
- ABA providers must be independently licensed professionals such as clinical social workers, clinical psychologists, or masters level therapists; or they must be behavior analysts certified by the Behavior Analyst Certification Board.
- ABA may be provided in an office setting, in the home or in another community setting outside of the classroom. Services provided in the classroom setting are not covered.

Diabetic Equipment, Supplies, Self-Management Education and Training Services

Covered expenses include diagnosis and treatment of diabetes including testing material used to detect the presence of sugar in the person's urine or blood for monitoring glycemic control, Medically Necessary testing supplies, equipment, drugs and other supplies prescribed by your physician.

Covered expenses include charges for necessary diabetes self-management education to ensure that covered persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition; including information on proper diets. Coverage for self-management education and education relating to diet will be limited to visits necessary upon the diagnosis of diabetes; where a physician diagnoses significant change in the patient's symptoms or conditions which necessitate change in a patient's self-management; or where reeducation or refresher education is necessary. Such education may be provided by the physician or other licensed health care provider; or their staff; as part of an office visit for diabetes diagnosis or treatment; or by a certified diabetes nurse educator; certified nutritionist; certified dietitian or registered dietitian upon the referral of a physician or other

licensed health care provider. Education provided by the certified diabetic nurse educator; certified nutritionist; certified dietitian; or registered dietitian may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet will also include home visits when necessary.

And used here:

“Diabetic self-management education” is training designed to instruct a person in the self-management of diabetes. It may include training in self-care or diet.

When diabetic self-management education is provided by a certified diabetes nurse educator; certified nutritionist; certified dietitian or registered dietitian upon referral by a physician; such education may be provided in a group setting. When necessary; diabetic self-management education shall also include home visits.

Charges incurred for the following are not included:

- A diabetic education program whose only purpose is weight control; or that is available to the public at no cost; or
- A general program not just for diabetics; or
- A program made up of services not generally accepted as necessary for the management of diabetes.

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. You do not need a referral from your PCP to obtain care from participating mental health and substance abuse providers. Instead, when you need mental health or substance abuse treatment, call the Member Services telephone number shown on your ID card and select the Aetna Behavioral Health option. A clinical care manager can assess your situation and refer you to participating providers, as needed. You may also find participating providers on www.aetna.com, or by consulting your PCP.

Mental Health Treatment

The Plan covers the following services for mental health treatment:

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

Treatment of Alcohol and Drug Abuse

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

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

Prescription Drugs

Prescription drug benefits are administered by Express Scripts. Questions regarding prescription drug benefits should be directed to Express Scripts at 1-866-713-7779. Representatives are available 24 hours, 7 days per week, except Thanksgiving and Christmas Day.

With Express Scripts as the prescription drug benefit administrator, you have access to a network of retail pharmacies and the Express Scripts Pharmacy®, Express Scripts home delivery service. Express Scripts also provides services which help the Plan promote and enforce the appropriate use of medications, such as review for possible excessive use; proper dosage; drug interactions or drug/pregnancy concerns.

Prescription drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative in order to be Covered Services. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before Express Scripts can determine Medical Necessity. The Administrator may, in its sole discretion, establish quantity limits, prior authorizations or other plan limits for specific prescription drugs. Covered Services will be limited based on Medical Necessity, quantity limits established by the Plan or utilization guidelines. Please ask your Provider or Network pharmacist to check with Express Scripts to verify any applicable limits or utilization guidelines.

The Plan pays, subject to any limitations specified under the [Your Benefits](#) section on Page 12, the cost incurred for outpatient prescription drugs that are obtained from a participating pharmacy. You must present your Express Scripts ID card and make the Copay shown in the [Schedule Of Benefits](#) section on Page 7 for each prescription at the time the approved prescription is dispensed.

The Plan pays 100% for drugs manufactured/ marketed by the Johnson & Johnson Family of Companies (pharmacy and home delivery), and for approved prescription and over-the-counter tobacco cessation medications. The Plan covers the costs of prescription drugs, in excess of the Copay, that are:

- Medically Necessary for the care and treatment of an illness or injury, as determined by Express Scripts;
- Prescribed in writing by a Physician who is licensed to prescribe Federal legend prescription drugs or medicines; and
- Not listed under the [Prescription Drug Exclusions and Limitations](#) section on Page 25.

Each prescription is limited to a maximum 90-day supply with refills as authorized by your Physician (but not to exceed one year from the date originally prescribed). Non-emergency prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name products where permitted by law.

There is a separate annual prescription drug out-of-pocket maximum which is noted in the Schedule of Benefits section on page 7. Your prescription drug copays are applied to the annual prescription drug out-of-pocket maximum. Once the annual maximum is reached, the Plan covers eligible prescription drug charges at 100% for the remainder of the calendar year.

Prescription Drug Out-Of-Pocket Maximum

The prescription drug out-of-pocket maximum is the most you will need to pay within a Plan Year for your Copay amounts for prescription drugs purchased through a retail pharmacy or through home delivery within a Plan Year. The individual prescription drug out-of-pocket maximum is \$2,000. The family prescription drug Out-of-Pocket maximum is two times the individual amount, or \$4,000. The \$4,000 family prescription drug out-of-pocket maximum can be satisfied by any combination of individual prescription drug out-of-pocket maximum amounts. However, no one family member can satisfy more than the stated individual prescription drug out-of-pocket maximum toward meeting the family prescription drug out-of-pocket maximum. Once met, all eligible prescription drug expenses will be paid at 100% of the prescription drug's discounted price if purchased at a participating retail pharmacy or through home delivery for the remainder of the Plan Year. The prescription drug out-of-pocket maximum does not include ineligible expenses and, for prescription drugs purchased at a participating retail pharmacy or through home delivery, amounts that exceed a prescription drug's discounted price.

Home Delivery Drugs

Participants in the Plan who must take a drug for more than 30 days, including Participants who must take maintenance drugs for a chronic condition, may

obtain up to a 90-day supply of the drug via mail through the Express Scripts Pharmacy if authorized by their Physician. The minimum quantity dispensed by the home delivery pharmacy is for a 30-day supply, and the maximum quantity is for a 90-day supply. The Copay shown in the [Schedule Of Benefits](#) section on Page 7 will apply to each home delivery purchase. Contact Express Scripts at 1-866-713-7779 for information on getting started.

Specialty Medications

Express Scripts needs to review and approve all new prescriptions for Specialty Medications (excluding medications that are manufactured/marketed by the Johnson & Johnson Family of Companies) with your doctor before they can be covered under your prescription drug benefit.

If you or a covered dependent have a new prescription for a Specialty Medication, please ask your doctor to call Express Scripts at 1-800-417-1764 Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern Time to arrange a review of this medication to minimize delays in obtaining this medication at your local pharmacy. Your doctor will need to provide Express Scripts with detailed information to ensure it is being utilized based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective.

If you or a covered dependent was taking a Specialty Medication in 2015, this medication will not require prior review and approval until January 1, 2018.

Emergency Prescriptions

You may not have access to a participating pharmacy in an emergency or urgent care situation, or if you are traveling outside of the Plan's service area. If you must have a prescription filled in such a situation, the Plan will reimburse you as follows:

NON-PARTICIPATING PHARMACY

Coverage for items obtained from a non-participating pharmacy is limited to items connected to a covered emergency or out-of-area urgent care services. You must pay the pharmacy directly for the cost of the prescription. You are responsible for submitting a written request for reimbursement to Express Scripts, accompanied by the receipt for the prescription. Express Scripts will review your request and determine whether the event meets the qualifications for reimbursement. If approved, you will be reimbursed for 100% of the cost, minus any applicable Copay.

PARTICIPATING PHARMACY

When you obtain an emergency or urgent care prescription at a participating pharmacy (including an out-of-area participating pharmacy), you must pay the Copay. If there is an issue requiring that you pay in full at a participating pharmacy (e.g., no ID card at time of filling), you can submit a claim to Express Scripts for reimbursement. Reimbursement will only be provided for eligible prescription drugs provided at participating pharmacies. Claim forms are available on YBR.

Covered Drugs

The Plan covers the following:

- Outpatient prescription drugs when prescribed by a provider who is licensed to prescribe Federal legend drugs or medicines, subject to the terms, limitations and exclusions described in this supplement.
- FDA-approved prescription drugs when the off-label use of the drug has not been approved by the FDA to treat the condition in question, provided that:
 - Prior approval is obtained through Express Scripts;
 - The drug is recognized for treatment of the condition in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information); or
 - The safety and effectiveness of use for the condition has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.
- Diabetic supplies, as follows:
 - Diabetic needles and syringes;
 - Alcohol swabs;
 - Test strips for glucose monitoring and/or visual reading;
 - Diabetic test agents; and
 - Lancets (and lancing devices).
 - Insulin pumps and accessories
- Contraceptives and contraceptive devices, as follows:
 - Oral, transdermal, intravaginal contraceptives;
 - Diaphragm;
 - Injectable contraceptives;
- Approved tobacco cessation prescription drugs (e.g., nicotine spray, nicotine inhaler, bupropion, Zyban®) and over-the-counter medications (i.e., nicotine patch, nicotine gum, nicotine lozenge).

- Oral Fertility drugs
- Ostomy supplies
- Nutritional therapies

Prescription Drug Exclusions And Limitations**PRESCRIPTION DRUG EXCLUSIONS**

The following services and supplies are not covered by the Plan, and a medical exception is not available for coverage:

- Any drug that does not, by Federal or state law, require a prescription order (such as an over-the-counter drug), even when a prescription is written, except for approved tobacco cessation medications, diabetic supplies, emergency contraceptives, nutritional therapy, inhaling assisting devices, ostomy supplies.
- Any drug that is not Medically Necessary.
- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth, including (but not limited to) health and beauty aids.
- Compound medications, by nature, have multiple ingredients. Since they are not regulated by the U.S. Food and Drug Administration (FDA), they can pose serious risks to patients and may not even be effective to treat the diagnosed condition. Therefore, since the FDA does not confirm their quality, safety and effectiveness, compound medications are not covered under the prescription drug plan. If your Doctor prescribes a compound medication, ask him or her to prescribe you an FDA-approved medication and contact Express Scripts Customer Service at the phone number on your prescription ID card to make sure the prescription will be covered under your plan.
- Home delivery only prescriptions for Emergency Contraceptives, Relenza and Tamiflu.
- Allegra OTC and prescription dosage forms.
- Medication which is to be taken by you or administered to you, in whole or part, while you are a patient in a licensed Hospital or similar facility.
- Take-home prescriptions dispensed from a Hospital pharmacy upon discharge from the Hospital, unless the Hospital pharmacy is a participating retail pharmacy.
- Any medication that is consumed or administered at the place where it is dispensed.
- Immunization or immunological agents, including:
 - Biological sera;
 - Blood, blood plasma or other blood products administered on an outpatient basis; or
 - Allergy sera and testing materials.

- Drugs used for the purpose of weight reduction, including the treatment of obesity.
- Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.
- Drugs labeled "Caution—Limited by Federal Law to Investigational Use" and experimental drugs, unless part of a qualifying cancer clinical trial approved by the National Cancer Institute and/or the Commission on Cancer.
- Drugs prescribed for uses other than the uses approved by the FDA under the Food, Drug and Cosmetic Law and regulations except as indicated under the [Covered Drugs](#) section on Page 24.
- Medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use.
- Prescription drugs purchased prior to the effective date, or after the termination date, of coverage under this Plan.
- Replacement of lost or stolen prescriptions.
- Performance, athletic performance, or lifestyle-enhancement drugs and supplies.
- Test agents and devices, except diabetic test strips.
- Certain injectable drugs including infertility injectables, and injectables related to the treatment of a non-covered service.

PRESCRIPTION DRUG LIMITATIONS

The following limitations apply to the prescription drug coverage:

- A participating retail or home delivery pharmacy may refuse to fill a prescription order or refill when, in the professional judgment of the pharmacist, the prescription should not be filled.
- Prescriptions may be filled only at a participating retail or mail-order pharmacy, except in the event of emergency or urgent care. Plan participants will not be reimbursed for out-of-pocket prescription purchases from a non-participating pharmacy in non-emergency, non-urgent care situations.
- Plan participants must present their ID cards at the time each prescription is filled to verify coverage. If you do not present your ID card, your purchase may not be covered by the Plan, except in emergency and urgent care situations, and you may be required to pay the entire cost of the prescription.

Prior Authorization Requirement

- The Program includes a mandatory Prior Authorization feature for certain medications. Prior Authorization is a procedure that is intended to assist participants in obtaining the best clinical recommendations for a specified group of medications.

- All requests for clinical Prior Authorization should be initiated by calling 1-800-753-2851.
- The following is a list of therapeutic classes that fall under the Prior Authorization requirement. This list is subject to change as new therapeutic classes are introduced.
 - Erythroid Stimulants
 - Growth Hormones
 - Immune Globulins
 - Interferon Agents
 - Myeloid Stimulants
 - Respiratory Syncytial Virus Agents
- Since a retail pharmacist will need clearance from Express Scripts before filling a prescription for a drug requiring Prior Authorization, you may wish to call Express Scripts to find out if your drug is one that requires Prior Authorization before going to the pharmacy.

EXCLUSIONS AND LIMITATIONS

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture, except as described under the [Your Benefits](#) section on Page 12.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not Medically Necessary, as determined by Aetna or Express Scripts.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
 - Reconstructive surgery to correct the results of an injury;
 - Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function; and
 - Surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless Medically Necessary and provided by participating providers upon referral from your PCP.
- Custodial care and rest cures.
- Dental care and treatment, including (but not limited to):
 - Care, filling, removal or replacement of teeth;
 - Dental services related to the gums;
 - Apicoectomy (dental root resection);

- Orthodontics;
- Root canal treatment;
- Soft tissue impactions;
- Alveolectomy;
- Augmentation and vestibuloplasty treatment of periodontal disease;
- Prosthetic restoration of dental implants; and
- Dental implants.

However, the Plan does cover oral surgery as described under the [Your Benefits](#) section on Page 12.

- Educational services, special education, remedial education or job training. The Plan does not cover the treatment of learning disabilities, minimal brain dysfunction, and learning disorders, behavioral training or cognitive rehabilitation that is not for restoration of function lost as the result of an illness or an injury. Services, treatment, and educational testing and training related to behavioral (conduct) problems and learning disabilities are not covered by the Plan. This exclusion does not apply to approved ABA services as described on page 18.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational healthcare procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.

This exclusion will not apply to drugs:

- That have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
- That are being studied as part of a qualifying cancer clinical trial approved by the National Cancer Institute and/or the Commission on Cancer; or
- That Express Scripts has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.

This exclusion also will not apply to routine patient services associated with qualifying cancer clinical trials approved by the National Cancer Institute and/or the Commission on Cancer.

Refer to the [Glossary](#) section on Page 50 for a definition of "Experimental or Investigational."

- False teeth.
- Foot orthotics.
- Health services, including those related to pregnancy that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids, eyeglasses, or contact lenses or the fitting thereof.
- Hospice services that are:
 - Funeral arrangements, pastoral counseling or legal counseling;
 - Homemaker or caretaker services and any service not solely related to the care of the terminally ill patient; or
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work.
- Implantable drugs, except as described under the [Prescription Drugs](#) section on Page 21.
- Infertility services, except as described under the [Your Benefits](#) section on Page 12. Surrogacy health care expenses, including fertility assistance, for a gestational surrogate mother, unless the gestational surrogate mother is covered under this Plan.
- Nutritional support, except when administered enterally (i.e., by feeding tube) or parenterally (i.e., by intravenous administration) where the member has either (a) a permanent non-function or disease of the structures that normally permit food to reach the small bowel; or (b) disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires enteral or parenteral feedings to provide sufficient nutrients to maintain weight and strength commensurate with the member's overall health status. To be considered permanent, the impairment must be reasonably expected to exceed three months' duration. Aetna does not cover nutritional support that is taken orally (i.e., by mouth). Oral nutrition is not considered a medical item. Regular food products are not considered medical items. Regular food products include food thickeners, baby food, or other regular grocery products that can be mixed in blenders and used with an enteral system

regardless of whether these regular food products are taken orally or parenterally.

- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips, except as described under the [Prescription Drugs](#) section on Page 21.
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies and other similar items and services.
- Private duty or special nursing care.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services provided by your close relative (your spouse/partner, child, brother, sister, or the parent of you or your spouse/partner) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
 - Obtaining or continuing employment;
 - Obtaining or maintaining any license issued by a municipality, state or Federal government;
 - Securing insurance coverage;
 - Travel; and
 - School admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.
- Services and supplies that are not Medically Necessary.

- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.

- Specific injectable drugs, including:
 - Experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health;
 - Needles, syringes and other injectable aids, except as described under the [Prescription Drugs](#) section on Page 21;
 - Drugs related to treatments not covered by the Plan; and
 - Drugs related to the treatment of infertility, contraception, and performance-enhancing steroids, except as described under the [Prescription Drugs](#) section on Page 21.
- Specific non-standard allergy services and supplies, including (but not limited to):
 - Skin titration (wrinkle method);
 - Cytotoxicity testing (Bryan's test);
 - Treatment of non-specific candida sensitivity; and
 - Urine autoinjections.
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):
 - Primal therapy;
 - Chelation therapy;
 - Rolfing;
 - Psychodrama;
 - Megavitamin therapy;
 - Purging;
 - Bioenergetic therapy;
 - Vision perception training; or

- Carbon dioxide therapy.
- Thermograms and thermography.
- Treatment in a Federal, state or governmental facility, including care and treatment provided in a non-participating Hospital owned or operated by any Federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a crime, misdemeanor or felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under the [Your Benefits](#) section on Page 12.
- Treatment of sickness or injury covered by a workers' compensation law or occupational disease law, or by United States Longshoreman's and Harbor Worker's Compensation Act.
- Treatment of temporomandibular disorders (TMD), temporomandibular joint (TMJ) syndrome, including (but not limited to):
 - Treatment performed by placing a prosthesis directly on the teeth;
 - Surgical and non-surgical medical and dental services; and
 - Diagnostic or therapeutic services related to TMD or TMJ.
- Weight reduction programs and dietary supplements.

Limitations

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

IN CASE OF MEDICAL EMERGENCY

Guidelines

If you have a medical emergency, emergency care services are covered 24 hours a day, 7 days a week, anywhere in the world. Aetna has adopted the following definition of an emergency medical condition:

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

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

Some examples of emergencies are:

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

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

Call your PCP first, if possible. Your PCP is required to provide urgent care and emergency coverage 24-hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility, or dial 911 or your local emergency response service.

After assessing and stabilizing your condition, the emergency facility should contact your PCP so they can assist the treating Physician by supplying information about your medical history.

If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible. The emergency room Copay will be waived if you are admitted to the Hospital.

All follow-up care must be coordinated by your PCP.

If you go to an emergency facility for treatment that Aetna determines is non-emergency in nature, you will be responsible for the bill. The Plan does not cover non-emergency use of the emergency room.

Follow-Up Care After Emergencies

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

Urgent Care

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

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

Some examples of urgent medical conditions are:

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

Follow-up care provided by your PCP is covered, subject to the office visit Copay. Other follow-up care by participating specialists is fully covered with a **prior written or electronic referral** from your PCP, subject to the specialist copay shown in the [Schedule Of Benefits](#) section on Page 7.

What to Do Outside Your Aetna Service Area

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

If, after reviewing information submitted to Aetna by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information.

SPECIAL PROGRAMS

Aetna Vision Discount Program

Plan participants are eligible to receive discounts on eyeglasses, contact lenses and nonprescription items, such as sunglasses and contact lens solutions through the Aetna Vision Discount Program at thousands of locations nationwide. Call 1-800-793-8616 for information and the location nearest you.

Plan participants are also eligible to receive a discount off the provider's usual retail charge for Lasik surgery (the laser vision corrective procedure) offered by Cole/LCA-Vision LLC through the U.S. LASIK network. Included in the discounted price is patient education, an initial screening, the Lasik procedure and follow-up care. To find the closest surgeons, call 1-800-422-6600 and speak to a Lasik customer service representative.

Women's Healthcare

The Plan offers a variety of benefits and programs to promote good health throughout each distinct life stage.

Direct Access for OB/GYN Visits

This program allows a female Plan participant to visit any participating gynecologist for one routine well-woman exam (including a Pap smear) per year, without a referral from her PCP. The Plan also covers additional visits for treatment of gynecological problems and follow-up care, without a PCP referral. Participating general gynecologists may also refer a woman directly for appropriate gynecological services without the patient's having to go back to her participating PCP.

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

Confidential Genetic Testing For Breast and Ovarian Cancers

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

Infertility Case Management and Education

Aetna's infertility case management unit provides Plan participants with educational materials and assistance with coordinating covered infertility care. A dedicated team of registered nurses and infertility coordinators staffs the unit.

WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN

Refer to the “Eligibility” section of the General/Administrative Information Plan Details (or for retirees, the Salaried Retiree Medical Plan Description) (both are available on YBR) for information about eligibility.

COORDINATION OF BENEFITS AND CLAIMS

Coordination of Benefits

If you have coverage under another group plan(s), the benefits from the other plan(s) will be taken into account for determining benefits payable under this Plan.

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

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured; and
- "No-fault" and traditional "fault" auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law.

To find out if benefits under the Plan will be coordinated, the Plan must first determine which plan pays benefits first. The determination of which plan pays first is made as follows:

- The plan without a coordination of benefits (COB) provision determines its benefits before the plan that has such a provision.
- The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent. If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows:
 - The plan that covers the person as a dependent of a working spouse/partner will pay first;
 - Medicare will pay second; and
 - The plan that covers the person as a retired employee will pay third.
- If, as an active employee, you and/or your covered Dependent are eligible for Medicare, your and your covered Dependents' medical coverage will continue and be primary to Medicare for you and your covered Dependents.
- Except for children of divorced or separated parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first. When both parents' birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan doesn't have the parent birthday rule, the other plan's COB rule applies.
- When the parents of a dependent child are divorced or separated:

- If there is a court decree which states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the healthcare expenses of the child, the parent birthday rule, immediately above, applies;
- If a court decree gives financial responsibility for the child’s medical, dental or other healthcare expenses to one of the parents, the plan covering the child as that parent’s dependent determines its benefits before any other plan that covers the child as a dependent; or
- If there is no such court decree, the order of benefits will be determined as follows:
 - The plan of the natural parent with whom the child resides;
 - The plan of the stepparent with whom the child resides;
 - The plan of the natural parent with whom the child does not reside; or
 - The plan of the stepparent with whom the child does not reside.
- If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.
- The benefits of a plan which covers a person under a right of continuation under Federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.
- If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

If it is determined that the other plan pays first, the benefits paid under this Plan will be reduced. Aetna will calculate this reduced amount as follows:

- The amount normally reimbursed for covered benefits under this Plan;

Less

- Benefits payable from your other plan(s).

If your other plan(s) provides benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

Subrogation

If you or a covered family member receives benefits from the Plan as the result of an illness or injury caused by another person, the Plan has the right to be reimbursed for those benefits from any settlement or payment you receive from the person who caused the illness or injury. This means the Plan may recover costs from all sources (including insurance coverage) potentially responsible for making any payment to you or your covered dependent as a result of an injury or illness, including:

- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Med-pay coverage;
- Workers' compensation coverage;
- No-fault automobile coverage; or
- Any first party insurance coverage.

What You Need To Know

Here are some important points about the right of subrogation:

THE PLAN HAS A LIEN ON ANY PAYMENTS YOU RECEIVE

The Plan automatically has a lien, to the extent of any benefits it has paid, on any payment you've received from a third party, his/her insurer or any other source. The lien is in the amount of benefits paid under this Plan for treatment of the illness, injury or condition for which the other person is responsible.

YOUR COOPERATION IS REQUIRED

You may not do anything to interfere or affect the Plan's subrogation rights.

You also must fully cooperate with the Plan's efforts to recover benefits it has paid. This includes providing all information requested by the Claims Administrator or its representatives. As part of this process, you may be asked to complete and submit certain applications or other forms or statements. If you fail to provide this information, it will be considered a breach of contract and may result in the termination of your health benefits or the instigation of legal action against you.

YOU MUST NOTIFY AETNA

If a lawsuit or any other claim is filed to recover damages due to injuries sustained by you or a covered family member, you must notify Aetna. This must be done within 30 days of the date the notice of the lawsuit or claim is given to a person, including an attorney.

THE PLAN IS PAID FIRST

The Plan's subrogation rights are a first priority claim against all potentially responsible person(s) and must be paid before any other claim for damages.

Recovery of Third Party Payments

For more information, please see the "Recovery Of Payments – Subrogation and Reimbursement" section of the Active Medical Plan Details (or for retirees, the Salaried Retiree Medical Plan Description) (both are available on YBR).

The Plan is entitled to full reimbursement first from any payments made by any responsible person(s). This reimbursement must be made, even if the payment is not enough to compensate you or your covered family member in part or in whole for damages. The terms of this Plan provision apply and the Plan is entitled to full recovery whether or not any liability for payment is admitted by any potentially responsible person(s), and whether or not the settlement or judgment you receive identifies the medical benefits provided by the Plan. The Plan may be reimbursed from any and all settlements and judgments, even those for pain and suffering or non-economic damages only.

AETNA CHOOSES THE COURT FOR ANY LEGAL ACTION

Any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction Aetna selects. When you receive benefits under this Plan, you agree to this rule and waive whatever rights you have by reason of your present or future place of residence.

THE PLAN IS NOT RESPONSIBLE FOR YOUR ATTORNEY FEES

The Plan is not required to participate in or pay attorney fees to the attorney you hire to pursue your claim for damages.

INTERPRETING THIS PROVISION

If there is any question about the meaning or intent of the Plan's coordination of benefit provision, the Plan will have the sole authority and discretion to resolve all disputes as to how this provision will be interpreted.

Claim Procedures

A claim occurs whenever a Plan participant requests:

- An authorization or referral from a participating provider or Aetna; or
- Payment for items or services rendered.

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

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

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

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:
 - It is not included in the list of covered benefits;
 - It is specifically excluded;
 - A Plan limitation has been reached; or
 - It is not Medically Necessary.

For more information, please see the “Claims Procedures, Denials, Appeals” section of the Active Medical Plan Details (or for retirees, the Salaried Retiree Medical Plan Description) (both are available on YBR).

Note: Pharmacy claims must be submitted to Express Scripts. Reimbursement will only be provided for eligible prescription drugs provided at participating pharmacies. Eligible prescription drugs filled at a non-participating pharmacy will only be covered if part of the rendering of emergency services where the prescription could not have reasonably been filled by a Participating Pharmacy. Claim forms are available on YBR.

Pharmacy claims should be submitted to:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

WHEN COVERAGE ENDS

For information about termination of coverage, see the “When Coverage Ends” section of the Active Medical Plan Details (or for retirees, the Salaried Retiree Medical Plan Description) (both are available on YBR). For information about continuing coverage, see “COBRA Continuation Coverage” in the General/ Administrative Information Plan Details (or for retirees, the Salaried Retiree Medical Plan Description) (both are available on YBR).

MEMBER SERVICES

Customer service professionals (CSPs) are trained to answer your questions and to assist you in using the Plan properly and efficiently.

Call the toll-free Member Services number on your Aetna ID card [(1-877-512-0363) Hours of Operation: 8:00 a.m. – 7:00 p.m. M-F Eastern time] to:

- Ask questions about benefits and coverage;
- Change your PCP; or
- Notify Aetna about an emergency.

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

For questions regarding the prescription drug benefit, Express Scripts Member Services can be reached at 1-866-713-7779. Representatives are available 24 hours, 7 days per week, except Thanksgiving and Christmas Day.

Internet Access

You can access Aetna Navigator on the internet at www.aetna.com to conduct business with the Member Services department electronically.

When you visit the Member Services site, you can:

- Find answers to common questions;
- Change your PCP;
- View and print your new ID card; or
- Contact the Member Services department with questions.

Aetna Navigator also provides a single location for the health and medical issues that matter most to you. When you visit the website, you can see some of Aetna Navigator's distinct features:

- Interactive tools, including a medical dictionary, allergy and asthma quizzes, a pregnancy due-date calculator and a heart and breath odometer. To access these tools, look under "Take Action on Your Health."
- A preventive health schedule that includes recommendations for screenings and immunizations.

You can access Express Scripts on the internet at www.express-scripts.com/jnj.

When you visit the Express Scripts site, you can:

- Compare drug prices;
- Locate participating pharmacies.
- Order a new ID card; or
- Order refills for home delivery prescriptions.

YOUR RIGHTS AND RESPONSIBILITIES

As A Plan Participant, You Have A Right To:

- Get up-to-date information about the doctors and Hospitals participating in the Plan.
- Obtain primary and preventive care from the PCP you chose from the Plan's network.
- Change your PCP to another available PCP who participates in the Aetna network.
- Obtain covered care from participating specialists, Hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get healthcare during and after office hours.
- Be told how to get in touch with your PCP or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private in accordance with applicable law and the Plan's privacy practices, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your healthcare.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that you cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide.
- Get up-to-date information about the services covered by the Plan—for instance, what is and is not covered and any applicable limitations or exclusions.
- Get information about Copays and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the appeal process.

- Suggest changes in the Plan's policies and services.

As A Plan Participant, You Have The Responsibility To:

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

NOTICE OF PRIVACY PRACTICES

Johnson & Johnson and the Service Administrators are committed to protecting your privacy under the Plan. In accordance with applicable law, Johnson & Johnson and the Service Administrators will take appropriate measures to keep your personal health information confidential and will only use or disclose your information to administer benefits under the Plan or to comply with applicable legal requirements. The Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder ("HIPAA") requires the Plan to maintain the privacy of employees' personal health information and to allow you certain access to that information. The Plan's practices under HIPAA are described more fully in the Plan's privacy notice, available on YBR.

GLOSSARY

Copay	The fee that must be paid by a Plan participant to a participating provider at the time of service for certain covered expenses and benefits, as described in the Schedule Of Benefits section on Page 7.
Cosmetic Surgery	Any surgery or procedure that is not Medically Necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not: <ul style="list-style-type: none"> ▪ Restore bodily function; ▪ Correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or ▪ Correct or naturally improve a physiological function.
Covered Services and Supplies (Covered expenses)	The types of Medically Necessary services and supplies described in "Your Benefits."
Custodial Care	Any service or supply, including room and board, which: <ul style="list-style-type: none"> ▪ Is furnished mainly to help you meet your routine daily needs; or ▪ Can be furnished by someone who has no professional healthcare training or skills; or ▪ Is at a level such that you have reached the maximum level of physical or mental function and are not likely to make further significant progress.
Dental Services	Expenses for Physician's or dentists' services for X-ray exams involving one or more teeth, the tissue or structure around them, alveolar process or the gums. This exclusion does not apply to expenses for: <ul style="list-style-type: none"> • Treating or removing a malignant tumor. • Treating accidental injury to sound natural teeth when expenses are for Physician's services or X-rays and incurred within 12 months of the injury. Treatment includes replacing those teeth within the 12 months. • Hospital charges, room and board and necessary services and supplies if it is Medically Necessary (as determined by the Service Administrator) to hospitalize you (or your Dependent) for oral surgery. • Treating dysfunctional Temporomandibular Joint Syndrome (TMJ, including TMJ exam, X-rays, consultation, diagnostic models, corrective appliances (splints, arch bars or bite guards) and Medically Necessary related professional care.

<p>Detoxification</p>	<p>The process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed Physician, while keeping physiological risk to the patient at a minimum.</p>
<p>Durable Medical Equipment (DME)</p>	<p>Equipment determined to be:</p> <ul style="list-style-type: none"> ▪ Designed and able to withstand repeated use; ▪ Made for and used primarily in the treatment of a disease or injury; ▪ Generally not useful in the absence of an illness or injury; ▪ Suitable for use while not confined in a Hospital; ▪ Not for use in altering air quality or temperature; and ▪ Not for exercise or training.
<p>Emergency</p>	<p>A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:</p> <ul style="list-style-type: none"> ▪ Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; ▪ Serious impairment to bodily function; or ▪ Serious dysfunction of any bodily organ or part. <p>With respect to emergency services furnished in a Hospital emergency department, the Plan does not require prior authorization for such services if you arrive at the emergency medical department with symptoms that reasonably suggest an emergency condition, based on the judgment of a prudent layperson, regardless of whether the Hospital is a participating provider. All Medically Necessary procedures performed during the evaluation (triage and treatment of an emergency medical condition) are covered by the Plan.</p>
<p>Experimental or Investigational</p>	<p>Services or supplies that are determined by the Plan to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:</p> <ul style="list-style-type: none"> ▪ There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or

	<ul style="list-style-type: none"> ▪ Approval required by the U.S. Food and Drug Administration (FDA) has not been granted for marketing; or ▪ A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational or for research purposes; or ▪ It is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or ▪ The written protocol(s) or protocols used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or investigational or for research purposes; or ▪ It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or ▪ It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or ▪ It is provided or performed in special settings for research purposes.
Home Health Services	Those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by Aetna.
Hospice Care	<p>A program of care that is:</p> <ul style="list-style-type: none"> ▪ Provided by a Hospital, skilled nursing facility, hospice or duly licensed hospice care agency; ▪ Approved by Aetna; and ▪ Focused on palliative rather than curative treatment for a Plan participant who has a medical condition and a prognosis of less than twelve months to live.
Hospital	An institution rendering inpatient and outpatient services, accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A Hospital may be a general, acute care, rehabilitation or specialty institution.
Infertility	<ul style="list-style-type: none"> ▪ For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of

	<p>artificial insemination.</p> <ul style="list-style-type: none"> ▪ For a female who is age 35 or older, the inability to conceive after six months without contraception or after six cycles of artificial insemination.
<p>Medical Services</p>	<p>Those professional services of Physicians or other health professionals, including medical, surgical, diagnostic, therapeutic and preventive services authorized by Aetna.</p>
<p>Medically Necessary</p>	<p>These are health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would give to a patient for the purpose of:</p> <ul style="list-style-type: none"> ▪ Preventing, evaluating, diagnosing, or treating an illness, an injury, a disease or its symptoms. <p>The provision of the service, supply or prescription drug must be:</p> <ol style="list-style-type: none"> 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) 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. <p>For these purposes, “generally accepted standard 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 view of physicians or dentists practicing in relevant clinical areas and other relevant factors.</p>
<p>Mental or Nervous Condition</p>	<p>A condition which manifests signs and/or symptoms that are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Psychosis; ▪ Affective disorders; ▪ Anxiety disorders;

	<ul style="list-style-type: none"> ▪ Personality disorders; ▪ Obsessive-compulsive disorders; ▪ Attention disorders with or without hyperactivity; and ▪ Other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma or a physical or medical condition.
Out-of-Pocket Maximum (Medical)	The limit on the amount you will have to pay each Plan Year for eligible In-Network medical expenses. Once the Out-of-Pocket Maximum(s) are met, Eligible Charges will be paid by the Plan at 100% of the Prenegotiated Fee (for In-Network services) for the remainder of the Plan Year (Excluding prescription drugs).
Out-of-Pocket Maximum (Prescription Drugs)	The limit on the amount you will have to pay each Plan Year for eligible prescription drug charges. Once the Out-of-Pocket maximum(s) are met, eligible charges will be paid by the Plan at 100% for the remainder of the Plan Year (Excluding medical plan charges).
Outpatient	Services and supplies received while not confined as an inpatient.
Partial Hospitalization	Medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be provided in a Hospital or non-hospital facility that is licensed as an alcohol, drug abuse or mental illness treatment program by the appropriate regulatory authority.
Participating Provider	A provider that has entered into a contractual agreement with the Service Administrator to provide services to Plan participants.
Physician	A duly-licensed member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where they practice, and who provides medical services which are within the scope of their license or certificate.
Plan Benefits	The medical services, Hospital services, and other services and care to which a Plan participant is entitled, as described in this supplement.
Plan Participant	A Participant, as defined in the "Glossary" section of the Active Medical Plan Details section (or for retirees, the Salaried Retiree Medical Plan Description) (both are available on YBR), and who has elected coverage under the Aetna self-funded HMO option.

Primary Care Physician (PCP)	A participating Physician who supervises, coordinates, and provides initial care and basic medical services as a general or family care practitioner or, in some cases, as an internist or a pediatrician, to Plan participants; initiates their referral for specialist care; and maintains continuity of patient care.
Provider	A Physician, health professional, Hospital, Skilled Nursing Facility, home health agency, or other recognized entity or person licensed to provide Hospital or medical services to Plan participants.
Referral	Specific written or electronic direction or instruction from a Plan participant’s PCP, in conformance with Aetna’s policies and procedures, which directs the Plan participant to a participating provider for Medically Necessary care.
Service Area	The geographic area, established by Aetna and approved by the appropriate regulatory authority, in which a Plan participant must live or work or otherwise meet the eligibility requirements in order to be eligible as a participant in the Plan.
Skilled Nursing Facility	An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna to meet the reasonable standards applied by any of the aforesaid authorities.
Specialist	A Physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.
Substance Abuse	Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.
Terminal Illness	An illness of a Plan participant, which has been diagnosed by a Physician and for which they have a prognosis of twelve months or less to live.
Urgent Medical Condition	A medical condition for which care is Medically Necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP.
Walk-in Clinic	Walk-in Clinics are free-standing health care facilities. They are an alternative to a physician’s office visit for treatment of:

	<ul style="list-style-type: none">▪ Unscheduled, non-emergency illnesses and injuries;▪ The administration of certain immunizations; and▪ Individual screening and counseling services. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither: An emergency room; nor the outpatient department of a hospital shall be considered a Walk-in Clinic.
--	---

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