Marriott International, Inc. Benefits

Aetna Select Open Access (Gold)
Formerly: Open Access Aetna Select

Summary Plan Description
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PLEASE NOTE: Effective January 1, 2018, the name of the Plan has changed from “Marriott International, Inc. Medical Plan” to “Marriott International, Inc. Health & Welfare Benefit Plan.”
The following is the Summary Plan Description (SPD) of the Marriott International, Inc.

Aetna Select Open Access (Gold) coverage (referred to as the “Health Plan” or “Aetna Open Access”) which is offered through the Marriott International, Inc. Medical Plan (referred to as the “Medical Plan” or the “Plan”).

The Plan document will control in the event of any conflict between the provisions of the Plan and this Summary Plan Description (SPD). Employees of Marriott International, Inc. (the “Company” or “Marriott”) who participate in the Plan agree to accept the provisions of the Plan as they are today or as they may be amended in the future. It is the participant’s responsibility to know the provisions of the Plan. Participants will be informed of any major Plan changes as required by law. All Plan change notices should be kept with this information.

The Health Plan coverage under the Medical Plan is self-funded by the Company. Aetna Life Insurance Company (Aetna) and CVS/caremark, under arrangements with the Company, provide certain administrative and claim services for the Health Plan coverage, including a network of health care providers and participating pharmacies. In providing access to a network, neither the Plan nor the Company guarantees the benefits or services provided by the network. The network is not operated by the Plan or the Company.

The Company intends to continue the Plan indefinitely. However, because unforeseen circumstances may arise, the Company reserves the right to terminate the Plan. The Plan may be amended any time and from time to time by the Company through its most senior human resources executive as designated by the President of the Company. Copies of any such amendments shall be deposited with the General Counsel of Marriott for retention in Marriott’s permanent files. The Plan gives the Plan Administrator sole, absolute, and final discretion to determine eligibility for participation, to construe the terms of the Plan, and to resolve any factual issues relevant to participation in the Plan or benefit enrollment.

This SPD describes the medical benefits available under the Plan for those employees eligible for the Health Plan and who have elected to participate in the Health Plan. The Plan also covers other employees who have separate booklets to describe the benefits available to them. However, the Plan does not cover certain individuals, including, but not limited to, individuals classified by the Company as temporary employees, leased employees, seasonal or “pool” employees, and independent contractors. To confirm whether the medical benefits described in this SPD apply to you, contact the myHR® Service Center.

All previously issued Plan booklets and announcements are obsolete.

The benefits shown in this SPD may not apply to employees represented by unions and/or covered by collective bargaining agreements, depending on the terms of those agreements.

As a Plan participant, you are responsible for updating your address and phone number on the myHR Web site. You may notify your Human Resources representative if you do not have access to the Web site. If you do not update your contact information timely, you may not receive date sensitive benefit information. You should also notify your Human Resources representative if your Social Security Number is legally changed or incorrect.

**HOW TO CONTACT myHR®**

Current employees may access the myHR Web site at [www.4myHR.com](http://www.4myHR.com) for benefit Plan details. You will need your Enterprise ID (EID) and EID password. If you don’t know your EID or EID password, you can go on [www.4myHR.com](http://www.4myHR.com) for instructions on where to retrieve your EID or EID password.

Former employees may access the myHR Web site at [www.marriottbenefits.com](http://www.marriottbenefits.com) for benefit Plan details.

The myHR Web site is available 24 hours a day, seven days a week, and can be accessed from any computer with Internet access. The myHR Service Center Representatives are available at **1-888-88-4myHR** (1-888-884-6947) between 9:00 a.m. and 8:00 p.m. Eastern time, Monday through Friday. Outside the United States, Puerto Rico, and Canada, call **847-883-2084**. (This is a toll call.)
NOTE REGARDING WEBSITES: This communication contains referrals to various websites providing advice and other goods and services which are owned and operated by third party vendors. References to websites not sponsored by Marriott do not mean that Marriott endorses or accepts any responsibility for the content, use, or products and services made available through such websites. Marriott is not responsible for the actions, content, accuracy, privacy policies, opinions expressed, services provided, goods sold, or other links provided by these sites. Marriott is not responsible, either directly or indirectly, for any damages, or losses caused or alleged to have been caused by use of or reliance on the actions, content, accuracy, privacy policies, opinions expressed, goods, or services provided through these websites or made available through these resources. Should you have questions regarding these websites, you should address them directly with the site, administrator for the particular site.
HOW TO USE YOUR SUMMARY PLAN DESCRIPTION

This Summary Plan Description ( SPD) is your guide to the benefits available through the Health Plan. Please read this SPD carefully and refer to it when you need information about how the Health Plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about many of the special programs available to you as a Health Plan participant. For SPD term definitions, please reference the Important Plan Definitions section.

If you cannot find the answer to your question(s) in this SPD, call Member Services at 1-877-706-8776. (This number is also located on your Health Plan ID card.) A Customer Service Representative will be happy to help you.

You may also call the myHR Service Center to be connected by phone to the Health Plan’s Member Service Line. (See the Member Services section for more information.)

For information about your pharmacy benefits, call CVS/caremark at 1-888-698-0582.

TIPS FOR PARTICIPANTS

• Keep this SPD where you can easily refer to it.

• Keep your Health Plan ID card and your CVS/caremark pharmacy card in your wallet.

Emergencies are covered anytime, anywhere, 24 hours a day. (See the Benefits at a Glance and What the Health Plan Covers sections for emergency care guidelines.)
**BENEFITS AT A GLANCE**

This section contains an overview of the Marriott International, Inc. Aetna Select Open Access (Gold) coverage, hereinafter referred to as the “Health Plan.” For a thorough explanation of coverage, see the contents of this Summary Plan Description (SPD).

The Health Plan, through Aetna Select, offers medical benefits, provided you use a participating provider in the network. No benefits are provided for using providers outside the network.

Some of the benefits listed below may be subject to precertification. Please see the *Services And Supplies Which Require Precertification* section for more details.

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<td>Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual</td>
<td>$350</td>
<td>Not covered.</td>
</tr>
<tr>
<td>• Family</td>
<td>$700</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes the annual deductible, , medical and prescription drug copays)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual</td>
<td>$4,000</td>
<td>Not covered.</td>
</tr>
<tr>
<td>• Family</td>
<td>$8,000</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit per Person</td>
<td></td>
<td>Unlimited</td>
</tr>
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**ABOUT THE CHARTS BELOW**

The coinsurance percentages listed below reflect the Health Plan coinsurance percentages. This is the amount the Health Plan pays. You are responsible for paying any deductibles, copayments (copays), and the remaining coinsurance percentage. You are also responsible for full payment of any non-covered expenses you incur.

All covered expenses are subject to the deductible unless specifically stated in this *Benefits at a Glance* section.
## PREVENTIVE CARE

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<td>Adults only (age 18 and older). Includes coverage for immunizations and 1 exam per calendar year.</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
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<th>Well Child Exams</th>
<th>Network</th>
<th>Out-of-Network</th>
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<tr>
<td>Includes coverage for immunizations.</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>• First 12 months of life – 7 exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 13th-24th months of life – 3 exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 25th-36th months of life – 3 exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1 exam per calendar year for ages 3 through 17.</td>
<td></td>
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<th>Routine Vision and Hearing Exams</th>
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<td>If performed during the preventive care exams listed above.</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
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<td>1 exam per calendar year.</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
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<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
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<tr>
<td>HIV screening and counseling</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
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<tr>
<td>Gestational diabetes screening</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
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<td>HPV DNA testing</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
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<td>Domestic violence screening and counseling</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
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# ROUTINE CANCER SCREENINGS

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<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
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<td>Routine Prostate Specific Antigen Test</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
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<td>Routine Digital Rectal Exam</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
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<tr>
<td>Routine Pap Smear</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Routine Fecal Occult Blood Test</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Routine Sigmoidoscopy</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Routine Double Contrast Barium Enema</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Routine Colonoscopy</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

The following services are subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.

### PHYSICIAN SERVICES

<table>
<thead>
<tr>
<th>PHYSICIAN SERVICES</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits to a Primary Care Physician (PCP)</td>
<td>You pay a $15 copay, then the Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Office Visits to a Specialist</td>
<td>You pay a $35 copay, then the Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>E-Visit Online Internet Consultation by a PCP</td>
<td>You pay a $15 copay, then the Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>E-Visit Online Internet Consultation by a Specialist</td>
<td>You pay a $35 copay, then the Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Maternity (Prenatal Visits)</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>
### Family Planning Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Health Plan Contribution</th>
<th>Deductible and Copay</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Contraceptive Devices</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
<td></td>
</tr>
<tr>
<td>(associated office visit is payable in accordance with the type of expense incurred and the place where services is provided)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female Contraceptive Counseling Services - Office Visits.</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
<td></td>
</tr>
<tr>
<td>Voluntary Termination of Pregnancy (Outpatient)</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
<td></td>
</tr>
<tr>
<td>Voluntary Sterilization for Males (Outpatient)</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
<td></td>
</tr>
<tr>
<td>Voluntary Sterilization for Females (Inpatient)</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
<td></td>
</tr>
<tr>
<td>Voluntary Sterilization for Females (Outpatient)</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
<td></td>
</tr>
</tbody>
</table>

### Physician Office Visits-Surgery

<table>
<thead>
<tr>
<th>Type</th>
<th>Health Plan Contribution</th>
<th>Deductible and Copay</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>You pay a $15 copay, then the Health Plan pays 100%. No deductible applies.</td>
<td></td>
<td>Not covered.</td>
</tr>
<tr>
<td>Specialist</td>
<td>You pay a $35 copay, then the Health Plan pays 100%. No deductible applies.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Walk-In Clinics Non-Emergency Visit

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Health Plan Contribution</th>
<th>Deductible and Copay</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay a $15 copay, then the Health Plan pays 100%. No deductible applies. Minute Clinic (located in some CVS Pharmacies): You pay a $5 copay, then the Health Plan pays 100%. No deductible applies.</td>
<td></td>
<td></td>
<td>Not covered.</td>
</tr>
<tr>
<td>Service Description</td>
<td>Network</td>
<td>Out-of-Network</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>The Health Plan pays 100%.</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>(when not given by a physician or not in conjunction with an office visit)</td>
<td>No deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>The Health Plan pays 100%.</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>(when not part of the physical exam)</td>
<td>No deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician Services for Inpatient Facility and Hospital Visits</strong></td>
<td>The Health Plan pays 90% after the deductible is met.</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>You pay 10%.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comprehensive Lactation Support and Counseling Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactation Counseling Services</td>
<td>The Health Plan pays 100%.</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Maximum 6 visits per year (individual or group)</td>
<td>No deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits in excess of the maximum are covered under the Physician Services section of the Benefits at a Glance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Breast Pumps &amp; Supplies</strong></td>
<td>The Health Plan pays 100%.</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>URGENT AND EMERGENCY MEDICAL CARE SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>You pay a $35 copay, then the Health Plan pays 100%.</td>
<td>You pay a $35 copay, then the Health Plan pays 100%.</td>
<td></td>
</tr>
<tr>
<td>At a non-hospital free-standing facility.</td>
<td>No deductible applies.</td>
<td>No deductible applies.</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Emergency Room</strong></td>
<td>You pay a $200 copay, then the Health Plan pays 100%.</td>
<td>You pay a $200 copay, then the Health Plan pays 100%.</td>
<td></td>
</tr>
<tr>
<td>If you are admitted to a hospital as an inpatient immediately following a visit to an emergency room, your copay is waived.</td>
<td>No deductible applies.</td>
<td>No deductible applies.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Urgent Use of Urgent Care Provider or Non-Emergency Use of Emergency Room</strong></td>
<td>Not covered.</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>Ground, Air, or Water Ambulance</strong></td>
<td>The Health Plan pays 100%.</td>
<td>The Health Plan pays 100%.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No deductible applies.</td>
<td>No deductible applies.</td>
<td></td>
</tr>
<tr>
<td><strong>OUTPATIENT LAB AND X-RAY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and Preoperative Testing (except complex imaging services)</td>
<td>The Health Plan pays 100%.</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Complex Imaging</strong></td>
<td>The Health Plan pays 90%</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Laboratory Testing</td>
<td>Network</td>
<td>Out-of-Network</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>(when not given by a physician or not in conjunction with an office visit)</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic X-Rays</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>(except complex imaging services)</td>
<td>The Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>(when not given by a physician or not in conjunction with an office visit)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPATIENT SURGERY</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INPATIENT SURGERY</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Facility</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Room and board and other expenses. (includes maternity)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Inpatient Facility</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>60 days per calendar year.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SPECIALTY BENEFITS</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care (Outpatient)</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>100 visits per calendar year. Each visit by a nurse or therapist is 1 visit. Each visit by a home health aide up to 4 hours equals 1 visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing (Outpatient)</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>100 private duty nursing shifts per calendar year. 8 hours equal 1 shift.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPICE BENEFITS</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Room and board and other expenses. Unlimited maximum benefit per lifetime.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INFERTILITY TREATMENT</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.</td>
<td>Payable in accordance with the type of expense incurred and the place where the service is provided.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>INPATIENT RESIDENTIAL TREATMENT OF MENTAL DISORDERS AND SUBSTANCE ABUSE</strong></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility and Physician Expenses</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>INPATIENT HOSPITAL TREATMENT OF MENTAL DISORDERS AND SUBSTANCE ABUSE</strong></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Boards and Other Expenses</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>OUTPATIENT TREATMENT OF MENTAL DISORDERS AND SUBSTANCE ABUSE</strong></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>You pay a $15 copay, then the Health Plan pays 100%. No deductible applies.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Outpatient Other Than Office Visit</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>OUTPATIENT THERAPIES</strong></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational, and Speech Therapy (includes evaluations) Combined 90 visits per calendar year.</td>
<td>If performed in an office setting or in an outpatient hospital/outpatient facility setting (non-office), you pay a $35 copay, then the Health Plan pays 100%.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Payable in accordance with the type of expense incurred and the place where the service is provided.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Payable in accordance with the type of expense incurred and the place where the service is provided.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>
## Radiation Therapy
Payable in accordance with the type of expense incurred and the place where the service is provided. Not covered.

## Obesity Treatment (Surgical)

<table>
<thead>
<tr>
<th></th>
<th>Network Institutes of Quality (IOQ) Facility Only</th>
<th>Network (Non-IOQ Facility)</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Morbid Obesity Surgery (includes surgical procedure and acute hospital services).</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Outpatient Morbid Obesity Surgery</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)</td>
<td>1 procedure per lifetime.</td>
<td>Not covered.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

## Transplant Services

<table>
<thead>
<tr>
<th></th>
<th>Network Institutes of Excellence (IOE) Facility Only</th>
<th>Network (Non-IOE Facility)</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility and Non-Facility Expenses</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

## OTHER COVERED HEALTH EXPENSES

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>The Health Plan pays 90% after the deductible is met. You pay 10%.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Durable Medical and Surgical</td>
<td>The Health Plan pays 90%</td>
<td>Not covered.</td>
</tr>
<tr>
<td>OTHER COVERED HEALTH EXPENSES</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Equipment</strong></td>
<td>after the deductible is met. You pay 10%. <strong>Wigs:</strong> The Health Plan pays 90% after the deductible is met, up to $500 per calendar year. You pay the balance.</td>
<td></td>
</tr>
<tr>
<td><strong>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</strong> Covers medical in nature treatment only.</td>
<td>Payable in accordance with the type of expense incurred and the place where the service is provided.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>
| **Prescription Drugs** Pharmacy benefit program offered through CVS/caremark. | **Retail**  
Generic/30 day supply: You pay a $5 copay.  
Formulary Brand/30 day supply: You pay a 30% coinsurance (minimum $30; maximum $60) per prescription.  
Non-Formulary Brand/30 day supply: You pay 60% coinsurance (minimum $60; maximum $150) per prescription.  
**Mail Order**  
Generic/90 day supply: You pay a $10 copay.  
Formulary Brand/90 day supply: You pay a 30% coinsurance ($60 minimum copay; $120 maximum copay).  
Non-Formulary Brand/90 day supply: You pay 60% coinsurance ($120 minimum copay; $300 maximum copay) per prescription. | Not covered. Only covered at a participating pharmacy. |
| **Spinal Manipulation**  
20 visits per calendar year. | You pay a $35 copay, then the Health Plan pays 100%. No deductible applies. | Not covered. |

**ELIGIBILITY**

**ELIGIBLE EMPLOYEES**
You are eligible to participate in the Health Plan if it is offered at your workplace, you are either a non-temporary:

- Salaried employee, or
- Full-time hourly paid employee who works the number of hours required by your workplace to be eligible for benefits,

and you:
- Reside in a geographic area covered by the Health Plan, and
- Have completed your waiting period as designated by your workplace.

You are not eligible to participate in the Plan if you are classified as a temporary employee, leased employee, seasonal or “pool” employee, or an independent contractor (generally, even if you are later determined to be an “employee” as a result of a judicial or administrative determination).

**ELIGIBLE DEPENDENTS**
The chart and information below will help you determine whom you can enroll for coverage as a Plan dependent.

<table>
<thead>
<tr>
<th>Can I Enroll My…?</th>
<th>Yes, if the person is …</th>
<th>No, if the person is …</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spouse</strong></td>
<td>Your legally married spouse; or Your legal common-law spouse (see details below); Note: There may be tax consequences to enrolling your same-sex spouse. See Information on Tax Consequences for Domestic Partners and Same-Sex Spouses section.</td>
<td>Divorced, annulled, or legally separated from you; or Covered as an employee in the Plan; or In active military service; or Not living in the U.S.</td>
</tr>
<tr>
<td><strong>Domestic Partner</strong></td>
<td>Your same-sex or opposite-sex domestic partner; and: - Neither partner is married, legally separated, or involved in another domestic partnership; and - The partners do and will continue to share the same principal address; and - Each partner is at least age 18; and - The partners maintain an intimate, committed relationship of mutual caring and support; and - The partners agree to share basic living expenses during their domestic partnership and will permit anyone who is owed these expenses to collect from either partner. (Basic living expenses include medical care, rent or mortgage, utility bills, etc. Partners sharing basic living expenses do not have to contribute equally, but agree that both are responsible for these expenses.) Note: There may be tax consequences to enrolling your same-sex spouse. See Information on Tax Consequences for Domestic Partners and Same-Sex Spouses section.</td>
<td>A blood relation; or Covered as an employee in the Plan; or In active military service; or Not living in the U.S.</td>
</tr>
</tbody>
</table>
**Can I Enroll My...?**

<table>
<thead>
<tr>
<th></th>
<th>Yes, if the person is ...</th>
<th>No, if the person is ...</th>
</tr>
</thead>
</table>
| **Child Under Age 26** | Under age 26; and  
  • Is a natural or legally adopted child, or under your legal guardianship or legal custody; or  
  • Is a stepchild; or  
  • Is a child of your domestic partner. | Covered by another parent or domestic partner in the Plan; or  
Covered as an employee in the Plan; or  
Not living in the U.S.; or  
A foster child. |
| **Disabled Child Age 26 or Older** | Age 26 or older; and  
  • Is a natural or legally adopted child or under your legal guardianship or legal custody; or  
  • Is a stepchild; or  
  • Is a child of your domestic partner; and  
  • Is disabled (mentally impaired, physically handicapped, or totally disabled) as determined by the Plan Administrator; and  
  • Is a participant on the day before his or her 26th birthday. | Covered by another parent or domestic partner in the Plan; or  
Covered as an employee in the Plan; or  
Not living in the U.S.; or  
A foster child. |
| **Other Children (Medical Plans only)** | A child under a Qualified Medical Child Support Order (QMCSO). Call the myHR Service Center. | Not applicable. |
| **Relatives** | Under your legal guardianship or legal custody (see above). | Not under your legal guardianship or legal custody and, for example, is your sister, brother, parent, in-law, grandparent, grandchild, aunt, uncle, niece, nephew, ward, or boarder. |

*Does not apply to the SIMNSA Medical Plan Option or Group Term Life Insurance.*

**DEPENDENT VERIFICATION**

You will need to provide proof of your dependent’s status to enroll your dependent for coverage. When you add a dependent, you will be asked by the myHR Service Center to provide documents specified in its letter to you by a specified deadline that demonstrate your relationship and the current status of that relationship.

**COMMON-LAW MARRIAGE**

The Company offers coverage for eligible common-law spouses and their eligible children. To be eligible for coverage, common-law spouses:

- Must file federal and state income tax returns as a married couple;
- Must have the same rights, benefits, and obligations of other married couples;
- Must prove their marriage to the appropriate governmental authorities as necessary (for example, completing affidavits and other forms currently required to receive Social Security and/or Medicare benefits); and
- Must have the same legal rights relating to property, insurance, and survivorship that apply to couples married with a marriage license.
To enroll your common-law spouse (and his or her eligible children), call the myHR Service Center to obtain a Common-Law Spouse Affidavit, which you must complete and return to the myHR Service Center, postmarked within 31 days of your call. Once the myHR Service Center receives your completed affidavit, you will receive a Confirmation of Coverage indicating whether you meet the requirements and your common-law spouse is enrolled for coverage.

**ENROLLMENT**

**HOW TO ENROLL**

You must enroll in the Plan to be covered. You must also enroll in the Plan if you want to enroll your spouse and/or dependent children.

Use the myHR Web site to enroll online or you may enroll by calling the myHR Service Center.

You must enroll within your initial eligibility period. If you do not enroll during this time, you will be a late enrollee and must generally wait until the next annual enrollment period to enroll. (See “Late Enrollees” at the end of this section.)

If you enroll online, you can print a Confirmation of Enrollment, which is a copy of your benefit elections, for your records. If you enroll through a myHR Service Center Representative, a printed Confirmation of Enrollment will be mailed to your home approximately one week after you enroll. If you enroll by calling a representative and do not receive a Confirmation of Enrollment, call the myHR Service Center.

Review your Confirmation of Enrollment carefully to make sure that your benefit selections are correct. If you see a problem and do not call the myHR Service Center to correct the problem within 14 days of the Confirmation of Enrollment date, you may not be able to change your coverage until the next annual enrollment period, unless you experience a qualified life event.

**WHEN COVERAGE TAKES EFFECT**

**Newly Hired Employees**

Your initial eligibility period is determined by your workplace. Coverage will take effect on the day after your initial eligibility period is satisfied, provided you enrolled during your initial eligibility period.

**Newly Eligible Employees**

If a change in your employment status makes you newly eligible for Plan coverage, your initial eligibility period is the 31 days following your status change. Coverage will take effect on the later of either:

- The date following 31 days from your employment status change; or
- The date following the completion of any applicable waiting period for your workplace,

provided you enrolled during your initial eligibility period.

**Annual Enrollment**

If you enroll during the annual enrollment period, coverage will take effect on the first day of the next Plan Year, provided you remain eligible to participate in the Plan.
QUALIFIED LIFE EVENTS

After you enroll in the Plan, your coverage generally remains in effect for the entire Plan Year, unless you experience a qualified life event. A qualified life event is a work or life occurrence that affects your benefits (such as marriage) and may entitle you to make changes to coverage during the Plan Year.

You may be able to enroll in, change, or cancel coverage for yourself and/or any dependents by using the myHR Web site or by calling the myHR Service Center, generally within 31 days of the qualified life event.

In the following exceptions, you must notify the myHR Service Center within 60 days of the event:

- Birth;
- Adoption or placement for adoption;
- Loss of dependent status (e.g., divorce or a child reaching age 26);
- Loss of eligibility for Medicaid or coverage under the state’s Children’s Health Insurance Program (CHIP); or
- Become eligible for a premium assistance subsidy under Medicaid or the state’s Children’s Health Insurance Program (CHIP).

**NOTE:** If you do not notify the myHR Service Center within 60 days of the date of your divorce or legal separation, the dissolution of your domestic partnership, or your child’s loss of dependent status, your covered dependent(s) will not receive a COBRA continuation coverage notice and, therefore, may not be eligible to continue Plan coverage. (See the COBRA Continuation Coverage section.)

If you have a qualified life event, you may be asked to provide documentation to support your qualified life event.

In all cases, the change in your coverage must be consistent with the qualified life event. For example, if you have “You + Family” coverage and you and your covered spouse divorce during the Plan Year, you may only cancel Plan coverage for your spouse, and any stepchildren who lost eligibility for the Plan. You cannot cancel Plan coverage for your dependent children who are also enrolled in the Plan. Details about allowable changes can be found on the myHR Web site or by calling the myHR Service Center.

Qualified life events include:

- Your marriage;
- Your domestic partnership; Note: There may be tax consequences to adding your domestic partner to coverage. See **Paying For Your Domestic Partner’s or Same-Sex Spouse’s Coverage section.**
- Your divorce, annulment, or legal separation, or the dissolution of your domestic partnership;
- The birth, adoption, or placement for adoption of your child, or your obtaining legal custody or legal guardianship of a child;
- Your death or an eligible dependent’s death;
- A change in your (or your spouse’s or domestic partner’s) work schedule that causes a loss or gain of benefits;
- End of your coverage under your spouse’s or domestic partner’s plan;
- Beginning of your coverage under your spouse’s or domestic partner’s plan because he or she changes elections during his or her open or annual enrollment period;
- A change in your dependent’s eligibility that causes a loss or gain of benefits;
• A change in your coverage under another employer-sponsored plan;
• A change in your requirement to cover your dependent according to a qualified medical child support order (QMCSO);
• A change in your (or your dependent’s) eligibility for COBRA continuation coverage because, for example, the maximum coverage period has been reached (but not because of a failure to pay the premium or fraud); and
• Your (or your dependent’s) entitlement for Medicare or Medicaid.

For a complete list of qualified life events, call the myHR Service Center.

**When Coverage Takes Effect as a Result of a Qualified Life Event**

For birth, adoption, and placement for adoption, coverage will take effect retroactively to the date of your qualified event. For all other qualified life events, coverage will take effect the Saturday following the date you report the qualified life event.

**LATE ENROLLEES**

If you do not enroll yourself and/or your dependents within the initial eligibility period, or within 31 days (within 60 days, if applicable) of a qualified life event, you and/or your dependents will be considered late enrollees. Late enrollees can enroll in the Plan only during the annual enrollment period. Coverage for a late enrollee takes effect on the first day of the next Plan Year, provided he or she remains eligible to participate in the Plan.

**YOUR HEALTH PLAN CONTRIBUTIONS**

Your contributions are deducted from your paycheck on either a before-tax or an after-tax basis each pay period. You decide how you want your contributions deducted when you enroll in Plan coverage or during the annual enrollment period.

**BEFORE-TAX CONTRIBUTIONS**

When you pay for Plan coverage on a before-tax basis, you reduce your taxable income. This can help you save on federal and most state income taxes, as well as on Social Security taxes. However, the federal government places restrictions on when you may cancel Plan coverage. You may only cancel your (or your dependent’s) coverage during the Plan Year if you experience a qualified life event. (See “Qualified Life Events” in the Enrollment section for details.)

**AFTER-TAX CONTRIBUTIONS**

When you pay for Plan coverage with after-tax dollars, you must pay taxes on the contribution amount. This option allows you the flexibility to cancel your (or your dependent’s) coverage during the Plan Year. However, you do not receive the tax advantages of before-tax contributions.

**CONTRIBUTIONS FROM PARTICIPANTS WHILE ON A LEAVE OF ABSENCE OR RECEIVING DISABILITY PAYMENTS**

Your Plan coverage may continue for the duration of your approved leave of absence, up to a maximum of 24 months, provided you pay the required contributions during your absence.

You may use paid leave to pay for the cost of Plan coverage while you are on leave. If you do not use paid leave (or you do not have enough paid leave), you may be direct billed for the cost of Plan coverage. (See
“Paying for Benefits When Paychecks Do Not Cover Plan Contributions” and “Payment Process” below for more information.

If you want information on how to continue coverage, cancel coverage, or re-enroll upon the end of your leave of absence, call the myHR Service Center.

**PAYING FOR BENEFITS WHEN PAYCHECKS DO NOT COVER PLAN CONTRIBUTIONS**

If you are on an approved leave of absence and/or your paychecks do not cover your contributions required by the Plan, you may be direct billed for the cost of Plan coverage and you may have the ability to pre-pay the amount you owe for your benefits. If you are required to make a payment, a Billing Notice will be mailed to your address on file from the myHR Service Center.

**Payment Process**

**Billing Notice**

You will receive a Billing Notice if you owe three or more weeks of benefit deductions. Billing Notices will be mailed monthly on the second Wednesday of each month. The Billing Notice will indicate the total amount due by plan. Payment will be due on the first day of the following month. Partial payments will be accepted and applied to the plans you are enrolled in based on the order listed below (you cannot choose which plans to pay):

- Medical;
- Short-Term Disability (STD);
- Long-Term Disability (LTD);
- Group Term Life (GTL);
- Dental;
- Vision;
- Additional Accidental Death & Dismemberment (AD&D); and
- Health Care Spending Account.

If you receive a paycheck (for hours worked or for paid leave) before the myHR Service Center receives your payment, the amount you owe will be deducted from your paycheck. For example, if you return from a leave of absence, the amount due on your Billing Notice will be deducted from your paycheck if the myHR Service Center has not yet received your payment. If the myHR Service Center receives payment after the amount you owe is deducted from your paycheck, your payment will be applied to your future benefits coverage cost.

**Pre-Payment Option**

You also have the option to pre-pay for benefits. This option accommodates employees who want to pay for their benefits in advance or catch up on benefit payments without having to wait for a Billing Notice. You can request a Pre-payment Notice on the myHR Web site or by calling the myHR Service Center. You must include this notice with your pre-payment. Your pre-payment will be applied to the plans you are enrolled in based on the order listed on your Pre-payment Notice.

**How to Submit Payment**

Checks or money orders for benefit premium payments are to be made payable to Marriott International, Inc. and mailed to the address below. Your account number should be included on your payment. You can
locate your account number on the top of your Billing Notice or Pre-payment Notice. You must include a copy of your Billing Notice or Pre-payment Notice with your payment.

myHR Service Center
P.O. Box 1122
Carol Stream, IL 60132-1122

If you have questions about the amount you owe for your benefits or how to submit payments, contact the myHR Service Center.

Cancellation of Benefits Coverage
To keep your benefits current, you must make full payment by the due date on your Billing Notice. Benefits will be cancelled on the first Wednesday of each month if you owe 11 or more weeks of benefit contributions. Coverage will be cancelled back to the paid-through date. If you have questions, visit the myHR Web site or call the myHR Service Center. Any payments received after your coverage is cancelled will be refunded and will not extend your coverage.

REINSTATING COVERAGE FOLLOWING AN FMLA OR MILITARY LEAVE OF ABSENCE
If you have been absent from work on an approved Family and Medical Leave Act (FMLA) or military leave of absence, and lost coverage due to non-payment of premium or voluntary cancellation during your FMLA or military leave of absence, you may reinstate Plan coverage when you return from an FMLA or military leave by calling the myHR Service Center within 31 days of your return-to-work date or the date on your cancellation notice, whichever is later.

If you timely request reinstatement, Plan coverage will generally take effect the Saturday following the week-ending date that the myHR Service Center receives notification of your return-to-work date. However, you may choose to have your Plan coverage become effective back to the date your coverage ended. If you choose this option, you will be required to pay the missed contributions.

PAYING FOR YOUR DOMESTIC PARTNER’S OR SAME-SEX SPOUSE’S COVERAGE
The cost for covering domestic partners or same-sex spouses and their children is the same as the cost for covering spouses and children. However, state and/or federal tax law determines whether or not you may pay for your domestic partner’s or same-sex spouse’s coverage with before-tax or after-tax contributions.

Domestic Partners. Under federal law, coverage for a domestic partner is a taxable benefit, unless the domestic partner also qualifies as your dependent for tax purposes. If you wish to certify your domestic partner as a tax dependent, call the myHR Service Center for the appropriate paperwork.

Same Sex Spouse. Under federal law and some state and local laws, coverage for a same-sex spouse is a non-taxable benefit if you enroll for coverage before-tax. However, if your state and/or local law does not recognize same-sex marriages, coverage for a same-sex spouse is a taxable benefit (even if you elect before-tax coverage for yourself), unless that same-sex spouse qualifies as your state tax dependent. If you wish to certify your same-sex spouse as a tax dependent, call the myHR Service Center for the appropriate paperwork.

(See the Information on Tax Consequences for Domestic Partners or Same-Sex Spouses section for a detailed discussion of before-tax contributions, after-tax contributions, and imputed income.)
HOW THE HEALTH PLAN WORKS

ABOUT THE HEALTH PLAN
The Health Plan provides coverage for a wide range of medical expenses for the treatment of illness or injury. It does not provide benefits for all medical care. The Health Plan also provides coverage for certain preventive and wellness benefits. With the Health Plan, you can directly access any network physician, hospital, or other health care provider for covered services and supplies under the Health Plan.

The Health Plan will pay for covered expenses up to the maximum benefits shown in this SPD. Coverage is subject to all the terms, policies, and procedures outlined in this SPD. Not all medical expenses are covered under the Health Plan. Exclusions and limitations apply to certain medical services, supplies, and expenses. Refer to the What the Health Plan Covers, Exclusions and Benefits at a Glance sections to determine if medical services are covered, excluded, or limited.

The Health Plan provides access to covered benefits through a network of health care providers and facilities. These network providers have contracted with Aetna, an affiliate, or third party vendor to provide health care services and supplies to Health Plan participants at a reduced fee called the “negotiated charge.”

Except for emergency and urgent care services, benefits will only be paid when you use network providers and facilities.

AVAILABILITY OF PROVIDERS
The Health Plan cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any network provider may terminate the provider contract or limit the number of patients accepted in a practice. If the physician initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

ONGOING REVIEWS
Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under the Health Plan. If Aetna determines that the recommended services or supplies are not covered benefits, you will be notified. You may appeal such determinations by contacting Aetna to seek a review of the determination. Refer to the How to File a Claim and Your Appeal Rights sections of this SPD.

THE PRIMARY CARE PHYSICIAN
To access network benefits, you are encouraged to select a primary care physician (PCP) from the Health Plan’s network of providers at the time of enrollment. Each covered family member may select his or her own PCP. If your covered dependent is a minor or otherwise incapable of selecting a PCP, you should select a PCP on his or her behalf. You and your covered family members are not required to select a PCP.

To locate and select a PCP, go to Aetna’s Web site (listed on your Identification Card [ID card]). You can choose a PCP based on geographic location, group practice, medical specialty, language spoken, or hospital affiliation.

A PCP may be a general practitioner, family physician, internist, or pediatrician. Your PCP provides routine preventive care and will treat you for illness or injury.

A PCP coordinates your medical care, as appropriate, either by providing treatment or directing you to other network providers for other covered services and supplies. The PCP can also order lab tests and X-rays, prescribe medicines or therapies, and arrange hospitalization.
CHANGING PCPS
You may change your PCP at any time on Aetna’s Web site or by calling the Member Services toll-free number on your ID card. The change will become effective upon Aetna’s receipt and approval of the request.

SPECIALISTS AND OTHER NETWORK PROVIDERS
You may directly access specialists and other health care professionals in the network for covered services and supplies under the Health Plan. Refer to Aetna’s Web site or call the Member Services toll-free number on your ID card to locate network specialists, providers, and hospitals in your area. Refer to the Benefits at a Glance section for benefit limitations and out-of-pocket costs.

NOTE: You will receive an ID card. It identifies you as a member when you receive services from health care providers. If you have not received your ID card or if your card is lost or stolen, notify the Health Plan immediately by calling 1-877-706-8776 and a new card will be issued.
You will also receive an ID card for your pharmacy benefits from CVS/caremark. Call CVS/caremark at 1-888-698-0582 if your CVS/caremark ID card is lost or stolen.

ACCESSING NETWORK PROVIDERS AND BENEFITS
You may select a PCP or other direct access network provider from the network provider directory or by logging on to Aetna’s Web site and searching Aetna’s online directory for names and locations of physicians and other health care providers and facilities. You can change your PCP at anytime.

If a service you need is covered under the Health Plan but not available from a network provider or hospital in your area, contact Member Services by e-mail or at the toll-free number on your ID card for assistance.

If a network provider refers you to another provider or facility for services (for example, for lab work or outpatient surgery), it is your responsibility to confirm with the provider or facility that they are a network provider or facility.

You will not have to submit medical claims for treatment received from network health care professionals and facilities. Your network provider will take care of claim submission. The Health Plan will directly pay the network provider or facility for covered expenses, less any cost sharing required by you. You will be responsible for deductibles, coinsurance, and copayments, if any.

EXPLANATION OF BENEFITS
You will receive notification, called an “Explanation of Benefits (EOB),” of what the Health Plan has paid toward your expenses. It will indicate any amounts you owe toward your deductible, copayments, or coinsurance or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

YOUR SHARE OF ELIGIBLE EXPENSES
This following describes cost-sharing features, benefit maximums, and other important provisions. The specific cost-sharing features and the applicable dollar amounts or benefit percentages are contained in the Benefits at a Glance section.

Annual Network Deductible – Individual
This is an amount of network covered expenses incurred each calendar year for which no benefits will be paid. The network deductible applies separately to you and each of your covered dependents. After covered expenses reach the network deductible, the Health Plan will begin to pay benefits for covered network expenses for the rest of the calendar year.
**Annual Network Deductible – Family**
When you incur network covered expenses that apply toward the network deductibles for you and each of your covered dependents, these expenses will also count toward the network family deductible limit. Your network family deductible limit will be considered to be met for the rest of the calendar year once the combined covered network expenses reach the network family deductible limit in a calendar year.

**Calendar Year Maximum Benefit:** The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

**Copayment (Copay)**
This is a specified dollar amount of the negotiated charge required to be paid by you at the time you receive a covered service from a network provider. It represents a portion of the applicable expense.

**Coinsurance Percentage**
This is the percentage of your covered expenses that the Health Plan pays and the percentage of covered expenses that you pay. Once applicable deductibles have been met, the Health Plan will pay a percentage of the covered expenses, and you will be responsible for the rest of the costs. The coinsurance percentage may vary by the type of expense. Refer to the *Benefits at a Glance* section for coinsurance amounts for each covered benefit.

**Annual Out-of-Pocket Limit**
The annual out-of-pocket limit is the maximum amount you are responsible to pay for covered expenses during the calendar year. Once you satisfy the out-of-pocket limit, the Health Plan will pay 100% of most covered expenses that apply toward the limit for the rest of the calendar year.

The Health Plan has an individual annual out-of-pocket limit. This means once the amount of eligible expenses you or your covered dependent has paid during the calendar year meets the individual annual out-of-pocket limit, the Health Plan will pay 100% of most covered expenses for that person for the remainder of the calendar year.

There is also a family annual out-of-pocket limit. Your family annual out-of-pocket limit will be considered to be met for the rest of the calendar year once the combined covered expenses reach the family annual out-of-pocket limit in a calendar year. This means once the amount of eligible expenses you or your covered dependent has paid during the calendar year meets the family annual out-of-pocket limit, the Health Plan will pay 100% of most covered expenses for you and all your covered dependents for the remainder of the calendar year.

**Expenses That Do Not Apply to the Annual Out-of-Pocket Limit**
Certain covered expenses do not apply toward the annual out-of-pocket limit. These include:

- Charges over the recognized charge amount;
- The difference in the cost between the brand name drug and the direct generic equivalent;
- Any covered expenses which are payable by the Health Plan;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an urgent care provider; and
- Certain other covered expenses.
**Lifetime Maximum Benefit**
There is an unlimited lifetime maximum.

**Precertification**
Certain health care services, such as hospitalization, outpatient surgery, and certain other outpatient services and supplies, require precertification by the Health Plan to verify coverage for these services. You do not need to precertify services. Your attending physician is responsible for obtaining necessary precertification for you. To obtain precertification, your attending physician must call the Health Plan at the telephone number listed on your ID card. This call must be made in accordance with the timeframes specified below:

<table>
<thead>
<tr>
<th>Services Requiring Precertification</th>
<th>Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td>For non-emergency admissions</td>
<td>Your physician must call and request precertification at least 14 days before the date you are scheduled to be admitted.</td>
</tr>
<tr>
<td>For an emergency outpatient medical condition*</td>
<td>Your physician must call before the outpatient care, treatment, or procedure if possible, or as soon as reasonably possible.</td>
</tr>
<tr>
<td>For an emergency admission</td>
<td>Your physician or the facility must call within 48 hours, or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>For an urgent admission</td>
<td>Your physician or the facility must call before you are scheduled to be admitted. An “urgent admission” is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.</td>
</tr>
<tr>
<td>For outpatient non-emergency medical services requiring precertification</td>
<td>Your physician must call at least 14 days before the outpatient care is provided or the treatment or procedure is scheduled.</td>
</tr>
</tbody>
</table>

* Precertification is not required for emergency care (as defined in the Important Plan Definitions section).

The Health Plan will provide a written notification to you and your physician of the precertification decision. If your precertified expenses are approved, the approval is good for 60 days, as long as you remain a participant in the Health Plan.

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

If precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how the Health Plan’s decision can be appealed. You or your provider may request a review of the precertification decision pursuant to the Your Appeal Rights section of this SPD.

**Services and Supplies Which Require Precertification**
Precertification is required for the following types of inpatient and outpatient medical expenses:

- Complex imaging (MRI, CAT scan, etc.)
- Stays in a hospital;
- Stays in a skilled nursing facility;
• Stays in a rehabilitation facility;
• Stays in a hospice facility;
• Outpatient hospice care;
• Stays in a residential treatment facility for treatment of mental disorders and substance abuse;
• Home health care;
• Private duty nursing care;
• Partial hospitalization programs for mental disorders and substance abuse;
• Intensive outpatient programs for mental disorders and substance abuse;
• Amytal interview;
• Applied behavioral analysis;
• Biofeedback;
• Electroconvulsive therapy;
• Neuropsychological testing;
• Outpatient detoxification;
• Psychiatric home care services;
• Psychological testing; and
• Diagnostic complex imaging.

Cost Sharing For Network Benefits
You share in the cost of your benefits. Cost-sharing amounts and provisions are described in the Benefits at a Glance section.

You will need to satisfy any applicable deductibles before the Health Plan will begin to pay benefits.

For certain types of services and supplies, you will be responsible for any copayments shown in the Benefits at a Glance section.

After you satisfy any applicable deductible, you will be responsible for any applicable coinsurance for covered expenses that you incur. Your coinsurance is based on the negotiated charge. You will not have to pay any balance bills above the negotiated charge for that covered service or supply. You will be responsible for your coinsurance, up to the annual out-of-pocket limit.

Once you satisfy the annual out-of-pocket limit, the Health Plan will pay 100% of most covered expenses that apply toward the limit for the rest of the calendar year. Certain designated out-of-pocket expenses may not apply to the annual out-of-pocket limit. Refer to the Benefits at a Glance section for specific information and what expenses do not apply. Refer to the Benefits at a Glance section for the specific annual out-of-pocket limit.

The Health Plan will pay for covered expenses, up to the maximums shown in the Benefits at a Glance and What the Health Plan Covers sections. You are responsible for any expenses incurred over the maximum limits contained in the Benefits at a Glance and What the Health Plan Covers sections.

You may be billed for any deductible, copayment, or coinsurance amounts, or any non-covered expenses that you incur.
REQUIREMENTS FOR COVERAGE

To be covered by the Health Plan, services and supplies and prescription drugs must meet all of the following requirements:

- The service or supply or prescription drug must be covered by the Health Plan. For a service or supply or prescription drug to be covered, it must:
  - Not be an excluded expense under the Health Plan. Refer to the Exclusions section for a list of services and supplies that are excluded;
  - Not exceed the maximums and limitations outlined in this SPD. Refer to the Benefits at a Glance and What the Health Plan Covers sections for information about certain expense limits; and
  - Be obtained in accordance with all the terms, policies, and procedures of the Health Plan.

- The service or supply or prescription drug must be provided while coverage is in effect. See the Eligibility, Enrollment, Events That May Affect Health Plan Coverage, and COBRA Continuation Coverage sections for details about when coverage begins and ends.

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

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

To determine if a service, supply, or prescription is medical necessary, please call Member Services at 1-877-706-8776.

NOTE: Not every service, supply, or prescription drug that fits the definition for medical necessity is covered by the Health Plan. Exclusions and limitations apply to certain medical services, supplies, and expenses. For example, some benefits are limited to a certain number of days, visits, or a dollar maximum. Refer to the Benefits at a Glance and What the Health Plan Covers sections for the Health Plan limits and maximums. Also refer to the Prescription Drugs section.
WHAT THE HEALTH PLAN COVERS

Many preventive and routine medical expenses, as well as expenses incurred for a serious illness or injury, are covered. This section describes which expenses are covered expenses. Only expenses incurred for the services and supplies shown in this section are covered expenses. Limitations and exclusions apply.

Refer to the Benefits at a Glance section for information about applicable deductibles, coinsurance, copays, benefit maximums and frequency, and age limits that may apply to the covered expenses in this section.

PREVENTIVE CARE

This section on preventive care describes the covered expenses for services and supplies provided when you are well.

For additional information regarding covered visit charges made for preventive care services, call the Member Services number on your ID card.

Refer to the Benefits at a Glance section for the frequency limits that apply to these services, if not shown below.

NOTE: Some language changes in response to recent changes to preventive services coverage and women’s preventive health coverage under the Federal Affordable Care Act (ACA) may not be included in the enclosed booklet. However, please note that Aetna and CVS/caremark are administering medical and outpatient prescription drug coverage in compliance with the applicable components of the ACA and the AMA.

Routine Physical Exams

Covered expenses include charges made by your physician for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
• For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  o Screening and counseling services, such as:
    ▪ Interpersonal and domestic violence;
    ▪ Sexually transmitted diseases; and
    ▪ Human Immune Deficiency Virus (HIV) infections.
  o Screening for gestational diabetes.
  o High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once -three years.
• X-rays, lab and other tests given in connection with the exam.
• For covered newborns, an initial hospital check up.

Limitations:

Unless specified above, not covered under this Preventive Care benefit are charges for:

• Services which are covered to any extent under any other part of this Plan;
• Services which are for diagnosis or treatment of a suspected or identified illness or injury.
• Exams given during your **stay** for medical care;
• Services not given by a **physician** or under his or her direction;
• Psychiatric, psychological, personality or emotional testing or exams;

**NOTE:** Refer to the *Benefits at a Glance* section for details about any applicable deductibles, coinsurance, benefit maximums, and frequency and age limits for physical exams.

**Preventive Care Immunizations**
**Covered expenses** include charges made by your **physician** or a facility for:
• immunizations for infectious diseases; and
• the materials for administration of immunizations;

that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

**Limitations**
Not covered under this Preventive Care benefit are charges incurred for immunizations that are not considered Preventive Care such as those required due to your employment or travel.

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

• Mammograms;
• Fecal occult blood tests;
• Digital rectal exams;
• Prostate specific antigen (PSA) tests;
• Sigmoidoscopies;
• Pap smear;
• Double contrast barium enemas (DCBE); and
• Colonoscopies.

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.

**Limitations:**
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

• Services which are covered to any extent under any other part of this Plan.

**NOTE:**
1. Refer to the *Benefits at a Glance* for details about cost sharing and benefit maximums that apply to Preventive Care.
2. For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your **physician**, log onto the *Aetna* website www.aetna.com, or call the member services at the number on the back of your ID card.
Family Planning Services - Female Contraceptives
For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **covered expenses** when provided in either a group or individual setting. They are subject to the contraceptive counseling services visit maximum shown in your **Benefits at a Glance**.

The following contraceptive methods are **covered expenses** under this Preventive Care benefit:

**Voluntary Sterilization**
**Covered expenses** include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

**Covered expenses** under this Preventive Care benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

**Contraceptives**
**Covered expenses** include charges made by a **physician** or **pharmacy** for female contraceptive devices including the related services and supplies needed to administer the device.

When contraceptive methods are obtained at a **pharmacy**, **prescriptions** must be submitted to the pharmacist for processing.

**Limitations:**
Unless specified above, not covered under this Preventive Care benefit are charges for:
- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
- Services which are for the treatment of an identified **illness or injury**;
- Services that are not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- **Male** contraceptive methods, sterilization procedures or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care.

Family Planning Services - Other
Covered expenses include charges for certain family planning services, even though not provided to treat an illness or injury.

- Voluntary sterilization for males
- Voluntary termination of pregnancy

**Limitations:**
Not covered are:
- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your employer; and
• Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care.

NOTE:
1. Refer to the Benefits at a Glance for details about cost sharing and benefit maximums that apply to Family Planning Services - Other.

Well Woman Preventive Visits
Covered expenses include charges made by your physician for a routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:
• Services which are covered to any extent under any other part of this Plan;
• Services which are for diagnosis or treatment of a suspected or identified illness or injury;
• Exams given during your stay for medical care;
• Services not given by a physician or under his or her direction;
• Psychiatric, psychological, personality or emotional testing or exams.

Routine Vision and Hearing Exams
The Health Plan covers a routine eye and hearing exam when performed during the annual routine physical exam.

PHYSICIAN SERVICES
Physician Visits
Covered medical expenses include charges made by a physician during a visit to treat an illness or injury. The visit may be at the physician’s office, in your home, in a hospital, or other facility during your stay or in an outpatient facility. Covered expenses also include:
• Immunizations for infectious disease, but not if solely for your employment;
• Allergy testing and allergy injections; and
• Charges made by the physician for supplies, radiological services, X-rays, and tests provided by the physician.

Surgery
Covered expenses include charges made by a physician for:
• Performing your surgical procedure;
• Pre-operative and post-operative visits; and
• Consultation with another physician to obtain a second opinion before the surgery.

Anesthetics
Covered expenses include charges for the administration of anesthetics and oxygen by a physician, other than the operating physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

NOTE: Certain procedures need to be precertified by the Health Plan. Refer to “Precertification” in the

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How the Health Plan Works section for more information about precertification.

ALTERNATIVES TO PHYSICIAN OFFICE VISITS

Walk-In Clinic Visits
Covered expenses include charges made by network walk-in clinics for unscheduled, non-emergency illnesses and injuries, and the administration of certain immunizations administered within the scope of the clinic’s license.

Refer to Aetna’s Web site or call the Member Services toll-free number listed on your ID card to locate network walk-in clinics in your area.

Practitioners at walk-in clinics are able to write a prescription, if necessary, which may be filled at any network pharmacy.

You may choose to visit a walk-in clinic for diagnosis of common family illnesses, such as ear infections and strep throat, as well as to receive immunizations, such as flu shots.

Quick facts about walk-in clinics:
• They are staffed by board-certified practitioners;
• Generally, no appointment is necessary;
• They are open seven days a week;
• Most have day, weeknight, and weekend hours; and
• Most visits take about 15 minutes.

E-Visits
Covered expenses include charges made by your primary care physician (PCP) for a routine, non-emergency medical consultation. You must make your E-visit through the Health Plan’s authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found on Aetna’s Web site or by calling the Member Services number on your ID card.

HOSPITAL EXPENSES
Covered medical expenses include services and supplies provided by a hospital during your stay.

Room and Board
Covered expenses include charges for room and board provided at a hospital during your stay. Private room charges that exceed the hospital’s semi-private room rate are not covered unless a private room is required because of a contagious illness or immune system problem.

Room and board charges also include:
• Services of the hospital’s nursing staff;
• Admission and other fees;
• General and special diets; and
• Sundries and supplies.

Other Hospital Services and Supplies
Covered expenses include charges made by a hospital for services and supplies furnished to you in connection with your stay.
Covered expenses include hospital charges for other services and supplies provided, such as:

- Ambulance services;
- Physicians and surgeons;
- Operating and recovery rooms;
- Intensive or special care facilities;
- Administration of blood and blood products and the cost of the blood or blood products;
- Radiation therapy;
- Speech therapy, physical therapy, and occupational therapy;
- Oxygen and oxygen therapy;
- Radiological services, laboratory testing, and diagnostic services;
- Medications;
- Intravenous (IV) preparations; and
- Discharge planning.

**Outpatient Hospital Expenses**
Covered expenses include hospital charges made for covered services and supplies provided by the outpatient department of a hospital.

**IMPORTANT REMINDERS**
The Health Plan will only pay for nursing services provided by the hospital as part of its charge. The Health Plan does not cover private duty nursing provided in a hospital setting.

If a hospital or other health care facility does not itemize specific room and board charges and other charges, the Health Plan will assume that 40 percent of the total is for room and board charge, and 60 percent is for other charges.

Hospital admissions must be precertified by the Health Plan. Refer to “Precertification” in the *How the Health Care Plan Works* section for details about precertification.

In addition to charges made by the hospital, certain physicians and other providers may bill you separately during your stay.

Refer to the *Benefits at a Glance* section for any applicable deductible, copay, coinsurance, and maximum benefit limits.

**EMERGENCY MEDICAL CONDITIONS**

**IN CASE OF A MEDICAL EMERGENCY**
When emergency care is necessary, please follow these guidelines:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your physician if a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
• If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.

You have coverage 24 hours a day, seven days a week, anywhere inside or outside the Health Plan’s service area for an emergency medical condition. No precertification is required for emergency care (as defined in the Important Plan Definitions section).

Covered expenses include charges made by a hospital or a physician for services provided in an emergency room to evaluate and treat an emergency medical condition.

The emergency care benefit covers:

• Use of emergency room facilities;
• Emergency room physicians services;
• Hospital nursing staff services; and
• Radiologists and pathologists services.

Contact your physician after receiving treatment for an emergency medical condition.

See “Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition” below for information on follow-up care.

NOTE: If you visit a hospital emergency room for a non-emergency condition, the Health Plan will not cover your expenses, as shown in the Benefits at a Glance section. No other Health Plan benefits will pay for non-emergency care in the emergency room.

URGENT CONDITIONS

In Case of an Urgent Condition
Call your physician if you think you need urgent care. Physicians usually provide coverage 24 hours a day, including weekends and holidays, for urgent care. You may contact any physician or urgent care provider for an urgent care condition if you cannot reach your physician.

If it is not feasible to contact your physician, do so as soon as possible after urgent care is provided. If you need help finding an urgent care provider, call Member Services at the toll-free number on your ID card, or you may access Aetna’s Web site.

You have coverage 24 hours a day, seven days a week, anywhere inside or outside the Health Plan’s service area for an urgent medical condition.

Covered expenses include charges made by an urgent care provider to evaluate and treat an urgent condition.

Your coverage includes:

• Use of urgent care facilities;
• Physicians services;
• Nursing staff services; and
• Radiologists and pathologists services.
Contact your physician after receiving treatment of an urgent condition.

See “Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition” below for information on follow-up care.

NOTE: If you visit an urgent care provider for a non-urgent condition, the Health Plan will not cover your expenses, as shown in the Benefits at a Glance section. No other Health Plan benefits will pay for non-urgent care from an urgent care provider.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition

Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for illness or injury. If you go to a hospital emergency room for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to the Benefits at a Glance section for cost-sharing information.

To keep your out-of-pocket costs lower, your follow-up care should be accessed through your PCP.

NOTE: Follow up care, which includes (but is not limited to) suture removal, cast removal, and radiological tests such as X-rays, should not be provided by an emergency room facility. If you go to a hospital emergency room for follow-up care, your expenses will not be covered, and you will be responsible for the entire cost of your treatment.

ALTERNATIVES TO HOSPITAL STAYS

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- An office-based surgical facility of a physician or dentist;
- A surgery center; or
- The outpatient department of a hospital.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a surgery center or hospital; and
- The surgery is not normally performed in a physician’s or dentist’s office.

NOTE: Benefits for surgery services performed in a physician's or dentist's office are described under “Physician Services” earlier in this section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the hospital or surgery center on the day of the procedure;
- The operating physician’s services for performing the procedure, related pre- and post-operative care, and administration of anesthesia. If anesthesia occurs during the same visit as the procedure, it is covered under the same copay; and
• Services of another physician for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

**Limitations**
Not covered under the Health Plan are charges made for:

• The services of a physician or other health care provider who renders technical assistance to the operating physician;
• A stay in a hospital; and
• Facility charges for office-based surgery.

**Birthing Center**
Covered expenses include charges made by a birthing center for services and supplies related to your care in a birthing center for:

• Prenatal care;
• Delivery; and
• Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

**Limitations**
Unless specified above, not covered under this benefit are charges:

• In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See “Pregnancy-Related Expenses” later in this section for information about other covered expenses related to maternity care.

**Home Health Care**
Covered expenses include charges for home health care services when ordered by a physician as part of a home health care plan and provided you are:

• Transitioning from a hospital or other inpatient facility and the services are in lieu of a continued inpatient stay; or
• Homebound.

Covered expenses include only the following:

• Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a hospital or skilled nursing facility after an inpatient stay, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous skilled nursing services. However, these services must be provided within 10 days of discharge.
• Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
• Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.

Each visit by a nurse or therapist is one visit. Each visit by a home health aid up to four hours is one visit.
Benefits for home health care visits are payable up to the home health care maximum listed in the Benefits at a Glance section.

This maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient; and
- Care is needed to transition from the hospital or skilled nursing facility to home care.

When the above criteria are not met, covered expenses include up to 12 hours of continuous care per day by an R.N. or L.P.N.

Coverage for home health care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or custodial care service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person’s non-skilled needs.

**Limitations**

Unless specified above, **not covered** under this benefit are charges for:

- Services or supplies that are not a part of the home health care plan;
- Services of a person who usually lives with you or who is a member of your or your spouse’s family;
- Services of a certified or licensed social worker;
- Services for physical, occupational, and speech therapy;
- Services for infusion therapy;
- Transportation;
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present; and
- Services that are custodial care.

**NOTES:** The Health Plan does **not** cover custodial care, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Refer to the Benefits at a Glance section for details about any applicable home health care visit maximums.

Home health care needs to be precertified by the Health Plan. Refer to “Precertification” in the How the Health Plan Works section for details about precertification.

**Hospice Care**

Covered expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program.

**Facility Expenses**

The charges made by a hospital, hospice, or skilled nursing facility for:

- Room and board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management; and
• Services and supplies furnished to you on an outpatient basis.

**Outpatient Hospice Expenses**
Covered expenses include charges made on an outpatient basis by a hospice care agency for:

• Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day.
• Part-time or intermittent home health aide services to care for you for up to eight hours a day.
• Medical social services under the direction of a physician. These include, but are not limited to:
  — Assessment of your social, emotional, and medical needs, and your home and family situation;
  — Identification of available community resources; and
  — Assistance provided to you to obtain resources to meet your assessed needs.
• Physical and occupational therapy.
• Consultation or case management services by a physician.
• Medical supplies.
• Prescription drugs.
• Dietary counseling.
• Psychological counseling.

Charges made by the providers below are covered if they are not employees of a hospice care agency, and such agency retains responsibility for your care:

• A physician for a consultation or case management;
• A physical or occupational therapist;
• A home health care agency for:
  — Physical and occupational therapy,
  — Part-time or intermittent home health aide services for your care up to eight hours a day,
  — Medical supplies,
  — Prescription drugs,
  — Psychological counseling, and
  — Dietary counseling.

**Limitations**
Unless specified above, **not** covered under this benefit are charges for:

• Daily room and board charges over the semi-private room rate.
• Funeral arrangements.
• Pastoral counseling.
• Financial or legal counseling. This includes estate planning and the drafting of a will.
• Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to, sitter or companion services for either you or other family members, transportation, and maintenance of the house.
Inpatient hospice care and home health care must be precertified by the Health Plan. Refer to “Precertification” in the How the Health Plan Works section for details about precertification.

**Private Duty Nursing**
Covered expenses include private duty nursing provided by a R.N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate. However, covered expenses will not include private duty nursing for any shifts during a calendar year in excess of the private duty nursing care maximum shifts. Each period of private duty nursing of up to eight hours will be deemed to be one private duty nursing shift.

The Health Plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:
- A change in your medication;
- Treatment of an urgent or emergency medical condition by a physician;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery; or
- An inpatient stay.

**Limitations**
Unless specified above, not covered under this benefit are charges for:
- Nursing care that does not require the education, training, and technical skills of a R.N. or L.P.N.;
- Nursing care assistance for daily life activities, such as:
  - Transportation,
  - Meal preparation,
  - Vital sign charting,
  - Companionship activities,
  - Bathing,
  - Feeding,
  - Personal grooming,
  - Dressing,
  - Toileting, and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation;
- Nursing care provided while you are an inpatient in a hospital or health care facility, provided the care can adequately be provided by the facility's general nursing staff, if it were fully staffed; and
• A service provided solely to administer oral medicine, except where law requires a R.N. or L.P.N. to administer medicines.

**Skilled Nursing Facility**
Covered expenses include charges made by a skilled nursing facility during your stay for the following services and supplies, up to the maximums shown in the *Benefits at a Glance* section, including:

- Room and board, up to the semi-private room rate. The Health Plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system.
- Use of special treatment rooms.
- Radiological services and lab work.
- Physical, occupational, or speech therapy.
- Oxygen and other gas therapy.
- Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or physician’s services).
- Medical supplies.

**NOTE:** Refer to the *Benefits at a Glance* section for details about any applicable skilled nursing facility maximums.

Admissions to a skilled nursing facility must be precertified by the Health Plan. Refer to “Precertification” in the *How the Health Plan Works* section for details about precertification.

**Limitations**
Unless specified above, **not** covered under this benefit are charges for:

- Charges made for the treatment of:
  - Substance abuse,
  - Senility,
  - Mental retardation, or
  - Any other mental illness, and
- Daily room and board charges over the semi-private rate.

**OTHER COVERED HEALTH CARE EXPENSES**

**Acupuncture**
The Health Plan covers charges made for acupuncture services provided by a physician if the service is performed as a form of anesthesia in connection with a covered surgical procedure.

**Alcoholism and Substance Abuse**
Covered expenses include charges made for the treatment of substance abuse and mental disorders by behavioral health providers.
**Inpatient Treatment for Alcoholism and Substance Abuse**

The Health Plan covers room and board at the semi-private room rate and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriately licensed by the State Department of Health or its equivalent.

Coverage includes:

- Treatment in a hospital for the medical complications of alcoholism or substance abuse. ("Medical complications" include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens, and hepatitis.)
- Treatment in a hospital, when the hospital does not have a separate treatment facility section.

**Outpatient Treatment for Alcoholism and Substance Abuse**

The Health Plan covers outpatient treatment of alcoholism and substance abuse.

The Health Plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or substance abuse. The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

**Partial Confinement Treatment for Alcoholism and Substance Abuse**

Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or substance abuse. The partial confinement treatment will only be covered if you would need a hospital stay if you were not admitted to this type of facility.

**NOTE:** Inpatient care must be precertified by the Health Plan. Refer to the *Precertification* section for more information about precertification.

**Treatment of Mental Disorders**

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers.

**NOTE:** Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See the *Exclusions* section for more information.

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility, or behavioral health provider's office for the treatment of mental disorders as follows:

**Inpatient Treatment**

Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital, or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

**NOTE:** Inpatient care, partial hospitalizations and outpatient treatment must be precertified by the Health Plan. Refer to the *Precertification* section for more information about precertification.
Partial Confinement Treatment
Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

NOTE: Inpatient care, partial hospitalizations and outpatient treatment must be precertified by the Health Plan. Refer to the Precertification section for more information about precertification.

Outpatient Treatment
Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital, or residential treatment facility.

The Health Plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

NOTE: Inpatient care, partial hospitalizations and outpatient treatment must be precertified by the Health Plan. Refer to the Precertification section for more information about precertification.

AMBULANCE SERVICE
Covered expenses include charges made by a professional ambulance service, as follows:

Ground Ambulance
Covered expenses include charges for transportation:

- To the first hospital where treatment is given in a medical emergency;
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition;
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition;
- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition (transport is limited to 100 miles); and
- When during a covered inpatient stay at a hospital, skilled nursing facility, or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air or Water Ambulance
Covered expenses include charges for transportation to a hospital by air or water ambulance when:

- Ground ambulance transportation is not available;
- Your condition is unstable and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one hospital to another hospital when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital, and the two conditions above are met.

Limitations
Not covered under this benefit are charges incurred to transport you:
• If an ambulance service is not required by your physical condition;
• If the type of ambulance service provided is not required for your physical condition; or
• By any form of transportation other than a professional ambulance service.

DIABETIC EQUIPMENT, SUPPLIES, AND EDUCATION
Covered expenses include charges for the following services, supplies, equipment, and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:
• External insulin pumps;
• Blood glucose monitors without special features unless required due to blindness;
• Alcohol swabs;
• Glucagon emergency kits;
• Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
• Foot care to minimize the risk of infection.
• Diabetic meters: if you go through CVS/caremark to obtain diabetic meters, it will be covered under your pharmacy benefit. Please note that if you choose to go through CVS/caremark, only certain brands of diabetic meters will be covered at 100% (please call CVS/caremark at 1-888-698-0582 for more details). If you want to use a different brand, your purchase through a medical supply retailer will be covered as a Durable Medical Equipment expense (deductible and coinsurance will apply).

DURABLE MEDICAL AND SURGICAL EQUIPMENT (DME)
Covered expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental, the initial purchase of DME if:
• Long-term care is planned; and
• The equipment cannot be rented or is likely to cost less to purchase than to rent.
The repair of purchased equipment is covered.
The replacement of purchased equipment is covered if:
• The replacement is needed because of a change in your physical condition; and
• It is likely to cost less to replace the item than to repair the existing item or rent a similar item.
The Health Plan limits coverage to one item of equipment for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.
Covered durable medical equipment includes those items covered by Medicare unless excluded in the Exclusions section of this SPD. The Health Plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of the Health Plan.
Maintenance and repairs needed due to misuse or abuse are not covered.

NOTE: Refer to the Benefits at a Glance section for details about durable medical and surgical equipment deductible, coinsurance, and benefit maximums. Also refer to the Exclusions section for
EXPERIMENTAL OR INVESTIGATIONAL TREATMENT
Covered expenses include charges made for experimental or investigational drugs, devices, treatments, or procedures, provided all of the following conditions are met:

• You have been diagnosed with cancer or a condition likely to cause death within one year or less.
• Standard therapies have not been effective or are inappropriate.
• The Health Plan determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment.
• There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  — The drug, device, treatment, or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  — The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  — The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
  — The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
  — You are treated in accordance with protocol.

OBESITY TREATMENT
Covered expenses include charges made by a physician, licensed or certified dietician, nutritionist, or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:

• An initial medical history and physical exam;
• Diagnostic tests given or ordered during the first exam; and
• Prescription drugs.

Morbid Obesity Surgical Expenses
Covered medical expenses include charges made by a hospital or a physician for the surgical treatment of morbid obesity of a covered person, provided the expenses are incurred at an Institute of Quality (IOQ) facility. If the expenses are not incurred at an IOQ facility, no payment will be made under the Plan.

Institutes of Quality Bariatric Surgery facilities are a national network of health care facilities that are designated based on measures of clinical performance, access, and efficiency for bariatric surgery. Bariatric surgery, also known as weight loss surgery, refers to various procedures to treat people living with morbid, or extreme, obesity.

Coverage includes the following expenses as long as they are incurred within a two-year period:

• One morbid obesity surgical procedure, including complications directly related to the surgery;
• Pre-surgical visits;
• Related outpatient services; and
• One follow-up visit.

This two-year period begins on the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

Complications, other than those directly related to the surgery, are covered under the related Health Plan’s covered medical expenses, subject to Plan limitations and maximums.

Panniculectomy (a surgical procedure performed to remove excess fat and skin in the stomach and abdominal areas) can be considered for coverage when both of the following criteria are met: (1) the panniculus hangs below the level of the pubis; and (2) the medical records document that the panniculus causes chronic intertrigo (dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing) that consistently recurs over three (3) months while receiving appropriate medical therapy, or remains refractory to appropriate medical therapy over a period of three (3) months.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

• Weight control services, including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants, and other medications;

• Exercise programs, exercise, or other equipment;

• Other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as described in this SPD; and

• Morbid obesity surgical benefits provided by out-of-network providers.

NOTE: Refer to the Benefits at a Glance section for information about any applicable benefit maximums that apply to morbid obesity.

OUTPATIENT LAB AND X-RAY

NOTE: Refer to the Benefits at a Glance section for details about any deductible, coinsurance, and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start, maintain, or change a plan of treatment prescribed by a physician. The charges must be made by a physician, hospital, or licensed radiological facility or lab.

Diagnostic Complex Imaging Expenses

The Health Plan covers charges made on an outpatient basis by a physician, hospital, or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

• C.A.T. scans;

• Magnetic Resonance Imaging (MRI); and

• Positron Emission Tomography (PET) scans.
Complex imaging expenses for preoperative testing will be payable under this benefit.

Complex imaging must be precertified by the Health Plan. Refer to the Precertification section for information about the precertification process.

**Limitations**

The Health Plan does not cover diagnostic complex imaging expenses under this part of the Health Plan if such imaging expenses are covered under any other part of the Health Plan.

If your tests indicate that surgery should not be performed because of your physical condition, the Health Plan will pay for the tests; however, surgery will **not** be covered.

**NOTE:** Complex imaging testing for preoperative testing is covered under the complex imaging section. Separate cost-sharing may apply. Refer to the Benefits at a Glance section for information about cost-sharing amounts for complex imaging.

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**Oral and Maxillofacial Treatment (Mouth, Jaws, and Teeth)**

Covered expenses include charges made by a physician, dentist, and hospital for non-surgical treatment of infections or diseases of the mouth, jaw joints, or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints, or supporting tissues (this includes bones, muscles, and nerves) and for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a stay required because of your condition are covered.

Dental work, surgery, and orthodontic treatment are covered if needed to remove, repair, restore, or reposition:

- Natural teeth damaged, lost, or removed; or
- Other body tissues of the mouth fractured or cut due to injury.

Any such teeth must have been free from decay or in good repair and are firmly attached to the jaw bone at the time of the injury.

The treatment must be completed in the calendar year of the accident or in the next calendar year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to injury, covered expenses only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.
Outpatient Preoperative Testing
Before a scheduled covered surgery, covered expenses include charges made for tests performed by a hospital, surgery center, physician, or licensed diagnostic laboratory, provided the charges for the surgery are covered expenses and the tests are:

- Related to your surgery, and the surgery takes place in a hospital or surgery center;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a hospital; and
- Not repeated in or by the hospital or surgery center where the surgery will be performed.

Test results should appear in your medical record kept by the hospital or surgery center where the surgery is performed.

PREGNANCY-RELATED EXPENSES
Covered expenses include charges made by a physician for pregnancy and childbirth services and supplies at the same level as any illness or injury. This includes prenatal visits, delivery, postnatal visits, and prenatal vitamins.

For inpatient care of the mother and newborn child, covered expenses include charges made by a hospital for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a Cesarean section.

A shorter stay is covered, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a birthing center as described under “Alternatives to Hospital Care” earlier in this section.

NOTE: Covered expenses also include services and supplies provided for circumcision of the newborn during the stay.

Comprehensive Lactation Support and Counseling Services
Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breast-feeding by a certified lactation support provider. Covered expenses also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are covered expenses when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your Benefits at a Glance.

Breast Pumps for Nursing Mothers
Health plans will help cover the purchase of a breast pump for nursing mothers. The coverage of breast pumps is tied into preventive care coverage. If there is a medical need for a pump with certain features or a particular brand, then the health care professional will indicate that on the prescription. The breast pump
appropriate to the customer's need is covered at no cost share with the appropriate prescription. Please check with the Plan for details.

PRESCRIPTION DRUGS
See the Prescription Drugs section.

PROSTHETIC DEVICES
Covered expenses include charges made for internal and external prosthetic devices and special appliances if the device or appliance improves or restores body part function that has been lost or damaged by illness, injury, or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The Health Plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease, injury, or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition or normal growth or wear and tear;
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes, but is not limited to:

- An artificial arm, leg, hip, knee, or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters, and external urinary collection devices;
- A speech-generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The Health Plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes or if the orthopedic shoe is an integral part of a covered leg brace;
- Trusses, corsets, and other support items; or
- Any item listed in the Exclusions section.

RECONSTRUCTIVE OR COSMETIC SURGERY AND SUPPLIES
Covered expenses include charges made by a physician, hospital, or surgery center for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
• Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.

• Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

**NOTE:** Injuries that occur as a result of a medical (i.e., non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

• Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when the defect results in:
  — Severe facial disfigurement; or
  — Significant functional impairment and the surgery is needed to improve function.

Reconstructive Breast Surgery
Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

SPECIALIZED CARE
Chemotherapy
Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise medically necessary based on your health status.

Radiation Therapy Benefits
Covered expenses include charges for the treatment of illness by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes. Coverage levels depend on where treatment is received.

Outpatient Infusion Therapy Benefits
Covered expenses include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a hospital; or
- A physician in his or her office or in your home.

“Infusion therapy” is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient infusion therapy services and supplies are covered expenses:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment, and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
• Chemotherapy;
• Drug therapy (includes antibiotic and antivirals);
• Pain management (narcotics); and
• Hydration therapy (includes fluids, electrolytes, and other additives).

**Not** included under this infusion therapy benefit are charges incurred for:

• Enteral nutrition;
• Blood transfusions and blood products not administered with blood administration;
• Dialysis; and
• Insulin.

Coverage for inpatient infusion therapy is provided under “Hospital Expenses” and “Skilled Nursing Facility” earlier in this section.

Benefits payable for infusion therapy will not count toward any applicable home health care maximums.

**NOTE:** Refer to the *Benefits at a Glance* section for details on any applicable deductible, coinsurance, and maximum benefit limits.

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**SPINAL MANIPULATION TREATMENT**

Covered expenses include charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the *Benefits at a Glance* section. However, this maximum does not apply to expenses incurred:

• During your hospital stay; or
• For surgery. This includes pre- and post-surgical care provided or ordered by the operating physician.

**THERAPY SERVICES (SHORT-TERM REHABILITATION)**

Covered expenses include charges for short-term therapy services when prescribed by a physician as described below, up to the benefit maximums listed in the *Benefits at a Glance* section. The services have to be performed by:

• A licensed or certified physical, occupational, or speech therapist;
• A hospital, skilled nursing facility, or hospice facility; or
• A physician.

Charges for the following short-term rehabilitation expenses are covered:

**Cardiac and Pulmonary Rehabilitation Benefits**

Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure, or myocardial infarction. The Health Plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12-week period.
Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six-week period.

**Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy, and Speech Therapy Rehabilitation Benefits**

Coverage is subject to the limits, if any, shown in the *Benefits at a Glance* section. Inpatient rehabilitation benefits for the services listed will be paid as part of your inpatient hospital and skilled nursing facility benefits provisions in this SPD.

- All therapies are subject to periodic medical necessity reviews as determined by the Health Plan.
- Physical therapy is covered for non-chronic conditions and acute illnesses and injuries, 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 or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries, 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, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and that is expected to restore the speech function or correct a speech impairment resulting from illness or injury or for delays in speech function development as a result of a gross anatomical defect present at birth. “Speech function” is the ability to express thoughts, speak words, and form sentences. “Speech impairment” is difficulty with expressing one’s thoughts with spoken words.
- Cognitive therapy employed with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A “visit” consists of no more than one hour of therapy. Refer to the *Benefits at a Glance* section for visit maximums. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

**NOTE:** Refer to the *Benefits at a Glance* section for details about the short-term rehabilitation therapy maximum benefit.

Unless specifically covered above, **not** covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down’s Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.
- Any services which are covered expenses, in whole or in part, under any other group health plan sponsored by an employer.
- Any services unless provided in accordance with a specific treatment plan.
• Services for the treatment of delays in speech development, unless resulting from illness, injury, or congenital defect.
• Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above.
• Services not performed by a physician or under the direct supervision of a physician.
• Treatment covered as part of the spinal manipulation treatment. This applies whether or not benefits have been paid under that section.
• Services provided by a physician or physical or occupational or speech therapist who resides in your home or who is a member of your family, or a member of your spouse’s family.
• Special education to instruct a person whose speech has been lost or impaired to function without that ability. This includes lessons in sign language.

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

- Heart;
- Lung;
- Heart/lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone marrow/stem cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (stem cell);
- Sequential transplants;
- Re-transplant of the same organ type within 180 days of the first transplant; or
- Any other single organ transplant, unless otherwise excluded under the Health Plan.

The following will be considered to be **more than one** transplant occurrence:

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

Benefits are only paid for a treatment received at a facility designated by the Health Plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will not be covered.

See the Medicare section for more information on benefits available to you if you have End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

The Health Plan covers:

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

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

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

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. **Pre-transplant evaluation/screening:** includes all transplant-related professional and technical components required for assessment, evaluation, and acceptance into a transplant facility’s transplant program;

2. **Pre-transplant/candidacy screening:** includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;

3. **Transplant event:** includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and

4. **Follow-up care:** includes all covered transplant expenses, home health care services, home infusion services, and transplant-related outpatient services rendered within 180 days from the date of the transplant event.
If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an IOE facility will be considered network care expenses.

**NOTE:** To ensure coverage, all transplant procedures need to be precertified by the Health Plan. Refer to “Precertification” in the *How the Health Plan Works* section for details about precertification. Refer to the *Benefits at a Glance* section for details about transplant expense maximums, if applicable.

**Limitations**
Unless specified above, **not** covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of the Health Plan;
- Services and supplies furnished to a donor when the recipient is not covered under the Health Plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue, or stem cells, without the expectation of transplantation within 12 months for an existing illness; and
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Health Plan.

**Network of Transplant Specialist Facilities**
Through the IOE network, you will have access to a provider network that specializes in transplants. The IOE facility must be specifically approved and designated by the Health Plan to perform the procedure you require. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

**TREATMENT OF INFERTILITY**
Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.
EXCLUSIONS

Not every medical service or supply is covered by the Health Plan, even if prescribed, recommended, or approved by your physician or dentist. The Health Plan covers only those services and supplies that are medically necessary and included in the What the Health Plan Covers section. Charges made for the following are not covered except to the extent listed under the What the Health Plan Covers section or by amendment attached to this SPD.

- Acupuncture, acupressure, and acupuncture therapy, except as provided in the What the Health Plan Covers section.
- Allergy: 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.
- Any charges in excess of the benefit, dollar, day, visit, or supply limits stated in this SPD.
- Any non-emergency charges incurred outside of the United States (1) if you traveled to such location to obtain prescription drugs or supplies, even if otherwise covered under this SPD, or (2) such drugs or supplies are unavailable or illegal in the United States, or (3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.
- Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.
- Behavioral health services:
  — Substance abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for detoxification or treatment of substance abuse is specifically provided in the What the Health Plan Covers section.
  — Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of his or her training in that field.
  — Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine, or nicotine use.
  — Treatment of antisocial personality disorder.
  — Treatment in wilderness programs or other similar programs.
  — Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the What the Health Plan Covers section of this SPD.
- Unless administered with blood administration: blood, blood plasma, synthetic blood, blood products or substitutes, including, but not limited to, the provision of blood, other than blood derived clotting factors. Any related services, including processing, storage, or replacement costs, and the services of blood donors are not covered. For autologous blood donations, only administration and processing costs are covered.
- Charges for a service or supply furnished by a network provider in excess of the negotiated charge or by an out-of-network provider.
- Charges submitted for services that are not rendered or rendered to a person not eligible for coverage under the Health Plan.
- Charges submitted for services by an unlicensed hospital, physician, or other provider or not within the scope of the provider’s license.
- Over-the-counter contraceptive supplies, including but not limited to, condoms, contraceptive foams, jellies, and ointments.
• Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

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

• Counseling: services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.

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

• Custodial care.

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

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

This exclusion does not include removal of bone fractures, removal of tumors, and orthodontogenic cysts.

• Disposable outpatient supplies: any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits, and splints, neck braces, compresses, and other devices not intended for reuse by another patient.
• Drugs, medications and supplies:
  — Over-the-counter drugs, biological or chemical preparations, and supplies that may be obtained without a prescription including vitamins;
  — Any services related to the dispensing, injection, or application of a drug;
  — Any prescription drug purchased illegally outside of the United States, even if otherwise covered under the Health Plan within the United States;
  — Immunizations related to work;
  — Needles, syringes, and other injectable aids, except as covered for diabetic supplies;
  — Drugs related to the treatment of non-covered expenses;
  — Performance-enhancing steroids;
  — Injectable drugs if an alternative oral drug is available;
  — Outpatient prescription drugs;
  — Self-injectable prescription drugs and medications;
  — Any prescription drugs, injectables, or medications or supplies provided by the policyholder or through a third party vendor contract with the contractholder;
  — Any expenses for prescription drugs, and supplies covered under the pharmacy plan administered by CVS/caremark will not be covered as a medical expense by Aetna under the Health Plan;
    (Prescription drug exclusions that apply to the pharmacy plan will apply to the medical expense coverage.)

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

• Examinations:
  — Any health examinations:
    — Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
    — Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
    — Required to travel, attend a school, camp, or a sporting event, or to participate in a sport or other recreational activity; and
    — Any special medical reports not directly related to treatment, except when provided as part of a covered service.

• Experimental or investigational drugs, devices, treatments, or procedures, except as described in the What the Health Plan Covers section.
• Facility charges for care services or supplies provided in:
  — Rest homes;
  — Assisted living facilities;
  — Similar institutions serving as individuals’ primary residences or providing primarily custodial or rest care;
  — Health resorts;
  — Spas or sanitariums; or
  — Infirmaries at schools, colleges, or camps.

• Food items: any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods, or other nutritional items, even if it is the sole source of nutrition.

  NOTE: Nutritional supplements (phenyl-free) and other food formulas to be taken at a physician’s direction if medically necessary for the treatment of inborn errors of metabolism are covered regardless of whether the formula requires a prescription for purchase.

• Foot care: except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet, or ankles, including, but not limited to:
  — Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain, or conditions caused by routine activities such as walking, running, working, or wearing shoes; and
  — Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments, and other equipment, devices, and supplies, even if required following a covered treatment of an illness or injury.

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

• Hearing:
  — Any hearing service or supply that does not meet professionally accepted standards;
  — Hearing exams given during a stay in a hospital or other facility; and
  — Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

• Home and mobility: any addition or alteration to a home, workplace, or other environment, or vehicle and any related equipment or device, such as:
  — Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
  — Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
  — Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables, and reclining chairs;
  — Equipment installed in your home, workplace, or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity, or temperature;
  — Other additions or alterations to your home, workplace, or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
  — Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;
  — Removal from your home, worksite, or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests, or other potential sources of allergies or illness; and
—Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

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

• Home uterine activity monitoring.

• Infertility: except as specifically described in the What the Health Plan Covers section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including, but not limited to:
  —Drugs related to the treatment of non-covered benefits;
  —Injectable infertility medications, including, but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
  —Artificial insemination;
  —Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including, but not limited to, in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); artificial insemination for covered females attempting to become pregnant who are not infertile as defined by the Health Plan;
  —Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
  —Procedures, services, and supplies to reverse voluntary sterilization;
  —Infertility services for females with FSH levels 19 or greater mIU/ml on Day 3 of the menstrual cycle;
  —The purchase of donor sperm and any charges for the storage of sperm, the purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy, donor egg retrieval or fees associated with donor egg programs, including, but not limited to, fees for laboratory tests;
  —Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.) and any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
  —Home ovulation prediction kits or home pregnancy tests;
  —Any charges associated with care required to obtain ART services (e.g., office, hospital, ultrasounds, and laboratory tests), and any charges associated with obtaining sperm for any ART procedures; and
  —Ovulation induction and intrauterine insemination services if you are not fertile.

• Maintenance care.

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

• Miscellaneous charges for services or supplies including:
  —Annual or other charges to be in a physician’s practice;
  —Charges to have preferred access to a physician’s services, such as boutique or concierge physician practices;
  —Cancelled or missed appointment charges or charges to complete claim forms;
  —Charges the recipient has no legal obligation to pay, or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
    —Care in charitable institutions,
    —Care for conditions related to current or previous military service,
    —Care while in the custody of a governmental authority,
    —Any care a public hospital or other facility is required to provide, or
    —Any care in a hospital or other facility owned or operated by any federal, state, or other governmental entity, except to the extent coverage is required by applicable laws.
• Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities).

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

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

• Private duty nursing during your stay in a hospital, and outpatient private duty nursing services, except as specifically described in “Private Duty Nursing” in the What the Health Plan Covers section.

• Transgender reassignment surgery: any treatment, drug, service, or supply related to changing sex or sexual characteristics, including:
  —Surgical procedures to alter the appearance or function of the body;
  —Hormones and hormone therapy;
  —Prosthetic devices; and
  —Medical or psychological counseling.

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

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

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

• Sexual dysfunction/enhancement: any treatment, service, or supply to treat sexual dysfunction, enhance sexual performance, or increase sexual desire, including:
  —Surgery, implants, devices, or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
  —Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services.

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

• Services that are not covered under the Health Plan.

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

• Speech therapy for treatment of delays in speech development, except as specifically provided in the What the Health Plan Covers section. For example, the Health Plan does not cover therapy when it is used to improve speech skills that have not fully developed.

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

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

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

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

• Transplant: transplant coverage does not include charges for:
  —Services obtained from a facility that is not designated as an IOE for the transplant being performed;
  —Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
  —Services and supplies furnished to a donor when the recipient is not a covered person;
  —Home infusion therapy after the transplant occurrence;
  —Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;
  —Harvesting and/or storage of bone marrow, tissue, or stem cells without the expectation of transplantation within 12 months for an existing illness;
  —Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified by the Health Plan; and
  —Services and supplies not obtained from an IOE, including the harvesting of organs, bone marrow, tissue, or stem cells for storage purposes.

• Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in the What the Health Plan Covers section.
• Unauthorized services, including any service obtained by or on behalf of a covered person without precertification by the Health Plan when required. This exclusion does not apply in a medical emergency or in an urgent care situation.

• Vision-related services and supplies, except as described in the What the Health Plan Covers section. The Health Plan does not cover:
  — Routine eye exams for refraction services;
  — Special supplies such as non-prescription sunglasses and subnormal vision aids;
  — Vision services or supplies which do not meet professionally accepted standards;
  — Special vision procedures, such as orthoptics, vision therapy, or vision training;
  — Eye exams during your stay in a hospital or other facility for health care;
  — Eye exams for contact lenses or their fitting;
  — Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
  — Replacement of lenses or frames that are lost or stolen or broken;
  — Acuity tests;
  — Eye surgery for the correction of vision, including radial keratotomy, LASIK, and similar procedures; and
  — Services to treat errors of refraction.

• Weight: any treatment, drug service, or supply intended to decrease or increase body weight, control weight, or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, except as described in What The Health Plan Covers section, including but not limited to:
  — Liposuction, banding, gastric stapling, gastric by-pass, and other forms of bariatric surgery, surgical procedures medical treatments, weight control/loss programs, and other services and supplies that are primarily intended to treat, or are related to the treatment of, obesity, including morbid obesity;
  — Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants, and other medications;
  — Counseling, coaching, training, hypnosis, or other forms of therapy; and
  — Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement.

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

**MEMBER SERVICES**
Member Service representatives are trained to answer your questions and to assist you in using the Health Plan properly and efficiently. Call the Member Service Line toll-free number at 1-877-706-8776 to ask questions about benefits and coverage.

**INCENTIVES**
To encourage you to access certain medical services when deemed appropriate by you in consultation with your physician or other service providers, Aetna may, from time to time, offer to waive or reduce your copayment, payment percentage, and/or a deductible otherwise required under the Plan or offer coupons or other financial incentives. Aetna has the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the availability of these arrangements to similarly-situated covered persons.

**CARE ADVOCATE TEAM**
As part of your Health Plan benefits, you have access to the Aetna Care Advocate Nurses (also called the “CAT Team”).

These programs are staffed by Registered Nurses who are dedicated to educating, supporting, guiding, and assisting you and your covered dependents with the Health Plan.

The nurses are available to take your calls between 8:00 a.m. and 6:00 p.m. Eastern time, Monday through Friday. Call the Member Services at 1-877-706-8776 to speak with a Care Advocate Team member. In addition to answering questions about your health care and educating you about health care services that are available, program representatives can:

- Be a resource for your medical questions;
- Call you before, during, and after a hospitalization to assist you with your health care needs and services;
- Work with your treating physician on precertification of medical equipment, hospitalizations, and other services that require precertification; and
- Coordinate referrals to and from various medical programs:
  - Maternity program,
  - Behavioral Health (mental/behavioral health, substance abuse),
  - Disease Management,
  - Complex Case Management,
  - National Medical Excellence (NME) transplants,
  - Pharmacy Management (prescriptions),
  - Ceridian (Marriott’s Employee Assistance program [EAP]),
  - Follow-up calls from the 24-hour nurse line, and
  - Occupational Health Nurses at certain Marriott locations.

For example, program representatives can:

- Help patients understand the goals and expected outcomes of their inpatient and complex outpatient treatments and services provided;
• Help identify the patient’s overall needs for recovery by assessing his or her treatment plan(s) and coordinating services for the patient, including referrals to disease and case management;

• Ensure continuity of care by acting as a liaison between various health professionals and services/benefits and by following the patient’s case from point of acute episode through post-discharge and referring to disease and case management when appropriate;

• Coordinate care and services so that participants can access them easily and quickly;

• Monitor progress to recovery of acute episodes;

• Attempt to prevent recurrence by working with the patient and other service partners to ensure the patient has the right access to care; and

• Increase outreach to participants whose primary language is other than English to ensure they understand the health care system.

DISEASE MANAGEMENT PROGRAM
The Aetna Health Connections℠ Disease Management Program supports over 34 chronic conditions. The disease management program can help participants:

• Get the treatment and preventive care they need;

• Understand and follow doctor’s treatment plan;

• Better manage ongoing conditions;

• Make changes to reach personal health goals; and

• Identify and manage risks for other conditions.

With this program, participants receive:

• Educational materials;

• Online resources;

• Nurse care management; and

• State-of-the-art technology that monitors participants’ health and safety.

Participants eligible for this program may receive a call from an Aetna nurse. Participants may also call the Member Services number on their ID card and ask to speak with a nurse.

WELLNESS COUNSELING
Aetna’s Wellness Counseling is available to help participants find balance and create a healthy lifestyle. Aetna’s team of health educators, dietitians, and other health professionals offer personal support.

Participants start by completing the online Health Assessment. Participants will answer questions about lifestyle habits, health history, and more. To take the Health Assessment on the phone, call the Member Services number on your ID card. Participants who score in a high-risk category will receive a call from a program health professional to find out how they can help. The Health Assessment is on a secure Web site, so information is protected.

Log on to www.Aetna.com to take the Health Assessment.

Your wellness counselor will work with you to:

• Choose the behaviors you want to change;

• Refer you to other programs that may help you;
• Set realistic goals and plans to ensure success;
• Work through challenges that might hold you back;
• Review other Health Plan health resources, from preventive health schedules to the 24-hour nurse helpline; and
• Set up a follow-up plan that’s just for you.

To learn more about the Wellness Counseling program, call the Member Services at 1-877-706-8776.

INTERNET ACCESS
You can access your Health Plan on the internet to conduct business with the Member Services department electronically at [www.Aetna.com](http://www.Aetna.com).

When you visit the Member Services Web site, you can:

• Find answers to common questions;
• Change your provider;
• Order a new medical ID card; or
• Contact Member Services with questions.

Please be sure to include your medical ID number and e-mail address.

For information specific to your Health Plan coverage with Marriott, information is also available on:

• [www.4myhr.com](http://www.4myhr.com); and

CLINICAL POLICY BULLETINS®
Aetna uses Clinical Policy Bulletins (CPBs) as guides when making clinical determinations about health care coverage. CPBs are written on selected clinical issues, especially addressing new technologies and new treatment approaches and procedures. Aetna participants can access the CPBs on Aetna’s Web site at [www.aetna.com/cpb](http://www.aetna.com/cpb).

AETNA NAVIGATOR™
Aetna Navigator provides a single location for the health and medical issues for Aetna participants.

In one easy-to-use Web site, you can perform a variety of self-service functions and take advantage of a vast amount of health information from InteliHealth. Access Aetna Navigator through the Aetna Web site home page or directly via [www.aetnanavigator.com](http://www.aetnanavigator.com).

When you visit the Web site, you can see some of Aetna Navigator's distinct features:

• A wealth of health information from InteliHealth, a premier provider of online consumer-based health, wellness, and disease-specific information;
• Online Member Service functions that allow you to change your Provider, order medical ID cards, and send e-mail inquiries to Member Services; and
• A preventive care planner that includes recommendations for screenings and immunizations.

You may also create password-protected Web pages that are personalized to your health care interests. You have access to the features listed above as well as other options including:

• A personal “benefits snapshot” and claims summary;
• “DocFind-A-Specialist,” Aetna’s enhanced online Provider directory that helps you select a specialist based on personal needs and preferences; and

• An online survey that allows you to receive customized information based on your personal health interests.

PERSONAL HEALTH RECORD
As a Health Plan participant, you have access to a free Personal Health Record (PHR) to track your own health care. Your PHR keeps track of your lab tests, injections, and diagnoses. It also gives you alerts about your health, such as when it’s time to have a mammogram or other preventive services.

No personal medical information is shared with Marriott. Information you provide is treated with the same confidentiality as any other medical record.

In most cases, when you go to the doctor, your PHR is automatically updated with your diagnosis, lab results, and any prescription drugs you may be taking.

Log on to www.Aetna.com to use your PHR.

BEHAVIORAL HEALTH SPECIALTY PROGRAMS
Aetna’s behavioral health case management and disease management programs offer support and coordinate behavioral health and wellness services to be sure participants and their doctors use Health Plan benefits to the fullest. Programs are offered to participants who have:

• Combined medical and behavioral health conditions;

• Symptoms of depression; and

• Anxiety disorders, such as generalized anxiety, panic disorder, and post traumatic stress syndrome.

To learn more about Aetna’s Behavioral Health specialty programs, call the Member Services number on your ID card or log onto www.aetnabehavioralhealth.com.

BEGINNING RIGHT® MATERNITY PROGRAM
Receive educational materials on:

• Prenatal care;

• Signs of preterm labor;

• What to expect before and after delivery; and

• Newborn care and more.

Participants can take a pregnancy risk survey to find out if any health conditions or risk factors could affect the pregnancy.

If identified as “at risk” or “high risk,” participants will receive two follow-up calls after delivery. Your nurse case manager will check in to see if you and your baby are doing well and give even more support if needed.

To learn more or to join the Beginning Right maternity program, call the Member Services number on your ID Card.

Go to Aetna Women’s Health online http://womenshealth.aetna.com for information about pregnancy and baby care, as well as:

• Reproductive health;

• Menopause;
• Breast health;
• Heart health;
• Migraines; and
• Depression.

INFORMED HEALTH® LINE
Talk to a registered nurse — 24/7 at 1-800-556-1555
Available 24 hours a day, seven days a week, the Informed Health Line gives participants a quick, simple way to get answers to health-related questions from a trained team of registered nurses. While only a doctor can diagnose, prescribe, or give medical advice, Informed Health Line nurses can offer information on more than 5,000 health topics. Always consult a doctor first with questions or concerns about health care needs.

Natural Products and Services
You can save on specialty health care products and services, including online consultations.

The ChooseHealthy® Program
Get at least 25% off standard charges for acupuncture, massage therapy, chiropractic and nutrition services, and save at least 15% off the manufacturer’s suggested retail price on health and wellness products. There are more than 19,000 participating professionals to choose from and a wide variety of health and wellness products such as:

• Over-the-counter vitamins, herbal and nutritional supplements
• Aromatherapy products and homeopathic remedies
• Natural body care products
• Yoga equipment

How you find participating natural therapy professionals and get your discount
• Use DocFind® to find a participating natural therapy professional.
• Set up an appointment. You’ll need to tell the office that you’re an Aetna member.
• There’s no need to contact Aetna for permission or precertification2
• Show your Aetna ID card at your appointment and pay the reduced rate.
• If your current Aetna plan includes coverage for some of these services, you may still take advantage of these discounts.

For more information or help finding a participating natural therapy professional near you, call ASH (American Specialty Health Systems Member Services toll free at 1-877-335-2746, 5 am - 6 pm PT, Mon-Fri.

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

2In certain states, the doctor may need to refer the member to a natural therapy professional before they can be treated.
**Vital Health Network**

Through the Vital Health Network (VHN), you have access to a network of doctors who either have an integrated medicine background or are licensed naturopathic physicians. They provide online consultations and alternative remedies for a variety of conditions such as allergies, cholesterol headaches, irritable bowel, prostate health, smoking cessation and more.

You can save 30% off the retail price of an online consultation with a VHN doctor for one topic, and 50% off the retail price of an online consultation for additional topics.

**How it works**

- Log in to the Vital Health Network
- Select a condition and fill out a registration form and questionnaire based on the condition selected.
- Your discount will be automatically applied during payment.
- Your information will be sent to a VHN doctor, who will review your information and begin a conversation with you via secure messaging.
- The doctor will give you a treatment plan, including easy-to-understand directions.

**Please note**

- VHN doctors will not prescribe any drugs.
- If the VHN doctor recommends an in-person examination, you can find an Aetna participating provider by using DocFind or calling Member Services.
- You can discuss more than one topic with your VHN doctor. If you want to consult with a VHN doctor about multiple topics, you must select another template and complete the questions. You will get a 30 percent discount on the first topic and a 50 percent discount on additional topics.

**Vision**

You can take care of your vision and save with EyeMed. Get discounts on eye exams, eyeglass frames and lenses, contact lenses and solutions, LASIK surgery, sunglasses and more.

With EyeMed Vision Care, you have access to a nationwide network of eye care providers at the following retail chains:

- Lenscrafters®
- Pearle Vision®
- Target Optical®
- Sears Optical® locations
- JCPenney® Optical

In addition, there are thousands of independent eye care providers to choose from.

**How it works**

- Visit DocFind or
- Call 1-800-793-8616 to find a participating provider.
- Call the provider’s office to schedule an appointment.
- Show your Aetna ID card to get your discount.

You can get these discounts even if you have other vision benefit coverage with Aetna. If you do have coverage, check your plan requirements first.

**Ready for LASIK?**
You can get a discount on LASIK screening surgery and follow up care through providers participating in the U.S. Laser Network. To access LASIK surgery discounts, call U.S. Laser Network Customer Service at 1-800-422-6600 (Mon-Fri, 8 am - 9 pm ET; Sat, 9 am - 6 pm ET).

Need to replace lost contact lenses?
If you have a current prescription and need replacement contact lenses, you can get extra pairs shipped to your home easily and quickly.
- Buy your first pair of prescription lenses through your doctor’s office.
- Then call Contacts Direct at 1-800-391 LENS (1-800-391-5367), (Mon-Fri, 8 am - 8 pm ET and Sat, 9 am - 5 pm ET) and use your current prescription to place an order for replacement lenses.

More Discounts
Log on to www.Aetna.com for information on more discounts.

FEDERAL NOTICES

This section describes laws and Plan provisions that apply to reproductive and women’s health issues, and your choice of primary care physicians.

THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT
Federal law generally prohibits restricting benefits for hospital lengths of stay to less than 48 hours following a vaginal delivery and less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending provider (physician, nurse-midwife, or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

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

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

THE WOMEN’S HEALTH AND CANCER RIGHTS ACT
In accordance with the Women’s Health and Cancer Rights Act, the Plan covers the following procedures for a person receiving benefits for an appropriate mastectomy:
- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedema.

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

For answers to questions about the Plan’s coverage of mastectomies and reconstructive surgery, call the Health Plan’s Member Services at 1-877-706-8776.
CHOICE OF A PRIMARY CARE PHYSICIAN
You are encouraged to select a primary care physician (PCP) from the Health Plan’s network of physicians. Each covered person may select his or her own PCP, provided the PCP participates in the Health Plan’s network and is available to accept you and/or your family members. For information on how to select a PCP and for a list of the participating PCPs, go to Aetna’s Web site or call the Member Services toll-free number (both of which are listed on your ID card).

For your covered child, you may designate a pediatrician as the primary care physician.

You do not need prior authorization from the Health Plan or from any other person (including a primary care physician) to obtain access to obstetrical or gynecological care from a health care professional in the Health Plan’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, go to Aetna’s Web site or call the Member Services toll-free number (both of which are listed on your ID card).

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

As a Plan participant, you have the responsibility to:
• Help your doctor make decisions about your health care;
• Tell your doctor 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;
• If you use in-network services, consult with your provider for non-emergency referrals to specialists or hospital care;
• If you use in-network services, see the specialists your provider refers you to;
• Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment;
• Be sure you are eligible for the highest level of benefit available by calling your provider before getting care at an emergency facility, unless a delay would be detrimental to your health;
• Understand that participating doctors and other health care providers who care for you are not employees of the Health Plan and that the Health Plan does not control them;
• Show your ID card to providers before getting care from them;
• Pay the co-pays required by the Health Plan;
• Call Member Services if you do not understand how to use your benefits;
• Promptly follow the Health Plan’s grievance procedures if you believe you need to submit a grievance;
• Give correct and complete information to doctors and other health care providers who care for you;
• Treat doctors and all providers, their staff, and the staff of the Plan with respect;
• Advise the Health Plan about other medical coverage you or your family members may have;
• Not be involved in dishonest activity directed to the Plan or any provider; and
• Read and understand your Health Plan and benefits. Know the co-pays and what services are covered and what services are not covered.
PRESCRIPTION DRUGS

CVS/caremark administers the prescription drug benefit and has an extensive network of participating retail pharmacies that offer discounted prices for your eligible prescription drugs. You must use a network pharmacy to receive prescription drug benefits for retail prescriptions. (See the Benefits at a Glance section.)

NOTE: A “Drug List” is a list of generic and brand-name prescriptions drugs that are chosen because of their safety, efficacy, and cost savings. Drugs on the Drug List can be purchased from both your participating retail pharmacy and CVS/caremark’s mail order service. You will be charged a lower co-pay for a prescription drug on the Drug List than for one that is not on the Drug List.

Most major pharmacies participate in the network. If your pharmacy is not listed in the materials sent to you by CVS/caremark, ask your pharmacist whether its pharmacy participates in the network. To locate a participating pharmacy, contact CVS/caremark at 1-888-698-0582 or visit its Web site at www.caremark.com.

To access CVS/caremark’s Web site, you must register and establish a user ID and password. Follow these easy steps, and make sure you have your CVS/caremark prescription ID card handy.

1. Go to www.caremark.com and click on “Not Registered?”
2. Enter the required information and click on “Continue.”
3. Create a username and password.

Your CVS/caremark prescription ID card is your prescription drug card. Use it when purchasing prescription drugs at participating pharmacies. If you are a new Plan participant and purchase prescription drugs before you receive your ID card, you will have to submit a claim to CVS/caremark for reimbursement, or request that your pharmacist call CVS/caremark to verify your coverage. For more information, call CVS/caremark at 1-888-698-0582.

SPECIAL RULES
The following rules apply to coverage for prescription drugs:

• The drug must be approved by the U.S. Food and Drug Administration (FDA);
• By law, the drug can only be dispensed by prescription and only by a licensed pharmacist; and
• A limited number of medications require pre-approval before filling the prescription. Contact Caremark at 1-888-698-0582 for additional information.

NOTE: If you purchase prescription drugs from a non-network pharmacy, you will have to pay the full cost. The Plan does not cover prescriptions filled at non-network pharmacies.

GENERIC DRUGS
Generally, you must use generic drugs when they are available. Direct generic equivalents have the same active ingredients as brand name drugs. Therapeutic generic equivalents (or “alternative generic(s)”) do not have the same active ingredients but they work the same way as brand name drugs.

• If you are prescribed a brand name drug when there is a direct generic equivalent available, the Plan will only cover the cost of the generic drug. If you take the brand name drug and do not change to the generic drug, you will pay the generic drug co-pay plus the difference in cost between the brand name drug and the generic drug, and the difference in the cost between the brand name drug and the direct
generic equivalent will not apply toward any annual deductible or out-of-pocket limit. This is illustrated by the following example:

- If you are prescribed Singulair (a brand name drug) and do not change to the generic drug, Montelukast, you will pay the generic drug co-pay plus the difference in cost between Singulair and Montelukast, as follows:

<table>
<thead>
<tr>
<th>You Pay</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic co-pay</td>
<td>$5</td>
</tr>
<tr>
<td>Cost of Singulair ($170), minus the cost of the direct generic equivalent, Montelukast ($32)</td>
<td>$138</td>
</tr>
<tr>
<td>Total Cost to You</td>
<td>$143</td>
</tr>
<tr>
<td>Amount applied toward any annual deductible or out-of-pocket limit</td>
<td>$5</td>
</tr>
</tbody>
</table>

(Note: The costs listed above are illustrative. Actual drug costs may vary by pharmacy. The generic co-pay listed above applies to most plans.)

If you are prescribed a brand name drug that does not have a direct generic equivalent but does have a therapeutic generic equivalent (an alternative generic), you will be urged to try the alternative generic first for 30 days. If you do not try the alternative generic first for 30 days, your brand name drug will not be covered by the Plan and you will have to pay the full cost of the brand name drug. For example, if you are prescribed Crestor (a brand name drug) and do not try an alternative generic, like Atorvastatin for 30 days, you will pay the full cost of Crestor, which costs about $170 for a 30-day supply. (Actual costs for Crestor may vary by pharmacy.)

* IMPORTANT: If your physician prescribes a brand name drug because you are allergic to the generic drug or because there is some other clinical reason why you cannot take the generic drug, your physician may contact CVS/caremark at 1-877-203-0003 to request approval of the brand name drug. If CVS/caremark approves the brand name drug, you will pay the regular cost for a formulary or non-formulary brand, depending on the medication.

**MAINTENANCE DRUGS**

A maintenance medication is any medication that is taken on a regular basis for an extended period of time, generally three months or more, e.g., medicine used to treat diabetes, asthma, high cholesterol or high blood pressure. Birth control medications are also considered maintenance medications.

As part of the Maintenance Choice Program, you have two choices for filling your maintenance medications:

1. Pick up your 90-day supply at your local CVS pharmacy store
2. Receive your 90-day supply in the mail through the CVS/caremark Mail Service Pharmacy. For additional information about the mail order benefit, visit CVS/caremark’s Web site at www.caremark.com, or call 1-888-698-0582 for more information.

You may receive up to three fills of a maintenance medication at any pharmacy that is in CVS/caremark’s network of participating pharmacies, e.g. Walgreens. After your third fill, you will be required to obtain your maintenance medications at your local CVS pharmacy store or through the CVS/caremark Mail Service Pharmacy. After your third fill, refills will not be covered at other pharmacies, e.g. Walgreens. However, if you contact CVS/caremark Customer Care at 888-698-0582, you can opt-out of the Maintenance Choice Program and can continue to fill your 30 day maintenance medication prescriptions at a retail pharmacy of your choice, subject to applicable cost share changes.

**PRESCRIPTION CONTRACEPTIVES**
Generic oral contraceptives are covered at 100%. Brand name drugs without a direct generic equivalent will also be covered at 100%. If a brand name drug has a direct generic equivalent, you will pay the generic drug co-pay plus the difference in cost between the brand name drug and the generic drug for the brand name drug.

There will be no co-pays for other approved devices, like IUDs or diaphragms.

**NOTE:** Some prescription drugs may not be available for up to a 90-day supply without a doctor’s approval.

See the *Benefits at a Glance* section for the prescription drug coverage.

**SPECIALTY MEDICATIONS**

You must use Caremark Specialty Pharmacy for specialty medications. Caremark Specialty Pharmacy will process your order and ship your injectable drug and administration supplies directly to your home or doctor’s office within approximately **72 hours** after receiving a valid prescription from your physician. Caremark Specialty Pharmacy will contact you before shipping.

To participate, call the Specialty Pharmacy CareTeam toll-free at **1-866-387-2573**. A Customer Service Representative will ask you for the following information:

- Your name and date of birth;
- Your phone number and address;
- The name of your injectable medication to be filled;
- Your doctor’s name and phone number; and
- Your CVS/caremark member ID number.

You also may refill your specialty prescription injectable drug by calling the Specialty Pharmacy CareTeam at **1-866-387-2573**. In most cases, specialty drugs can only be dispensed in a 30-day supply.

**HOW TO FILE A CLAIM FOR PHARMACY BENEFITS**

A claim for pharmacy benefits is any request for pharmacy benefits from CVS/caremark made in accordance with these claims procedures. A prescription that is adjudicated at a participating retail or mail order pharmacy will not be treated as a claim for benefits, unless it requires preauthorization.

**Authorized Representative**

You may have an authorized representative (including a treating health care professional) act on your behalf with respect to a benefit claim or appeal by notifying CVS/caremark, in writing, of that person’s name. In the case of an urgent care claim, CVS/caremark will automatically recognize a health care professional with knowledge of your medical condition (for example, the treating physician) as your authorized representative, unless you give CVS/caremark other instructions, in writing. (An “urgent care claim” is a claim that, if not decided quickly, could seriously jeopardize your life or health or ability to regain maximum function or would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without a prescription.) If you have an authorized representative, the Plan will direct all information, notification, etc., regarding your claim to the authorized representative. You will receive copies of all notifications regarding decisions, unless you give the Plan other instructions, in writing.

**NOTE:** If you have an authorized representative, all references to “you” in these claims procedures will include your authorized representative, where appropriate.
FILING A CLAIM

Reimbursement of Eligible Prescription Expenses Paid Out of Pocket

If you are a new Plan participant and purchase prescription drugs before you receive your ID card, you will need to submit a completed CVS/caremark claim form with an itemized pharmacy receipt as proof of the expenses. Be sure the pharmacy receipt includes all of the required information. You must file your claim as soon as possible after the prescription is filled, but no later than 12 months after the prescription is filled.

To obtain a claim form, call CVS/caremark at 1-888-698-0582. You may also download a claim form from the CVS/caremark Web site at www.caremark.com and click on “Prescriptions & Coverage.” Choose “My Coverage,” “Print Forms,” then “Paper Claim and Reimbursement Form.” You must register through the CVS/caremark Web site to get into the Marriott-specific Web page.

Send your completed claim form to:
CVS/caremark Claims Department
P.O. Box 52196
Phoenix, AZ 85072-2196

Prior Authorization

A limited number of drugs and medicines require pre-approval before filling the prescription. To determine if your prescriptions require pre-approval, contact CVS/caremark at 1-888-698-0582.

To obtain prior authorization, your physician must contact CVS/caremark at 1-800-626-3046 and provide all required information.

CVS/caremark will treat your preauthorization claim as an urgent care claim if a physician with knowledge of your medical condition tells CVS/caremark that your claim involves urgent care. (An “urgent care claim” is a claim that, if not decided quickly, could seriously jeopardize your life or health or ability to regain maximum function or would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without a prescription.)

If your preauthorization claim is incorrectly filed, you will be notified as soon as possible, but no later than five days after CVS/caremark receives the incorrectly filed claim and no later than 24 hours if it involves urgent care. The notification may be in writing or verbal (unless you specifically request written notification) and will describe the proper procedures for filing the claim.

NOTICE OF INITIAL CLAIMS DECISION

You will receive a decision from CVS/caremark regarding your claim as follows:

Claims for Reimbursement

You will receive a decision within a reasonable time, but no later than 30 days after CVS/caremark receives your claim, if the claim is denied, in whole or in part.

Preauthorization Claims

A decision will be made and communicated within a reasonable time appropriate to the medical circumstances, but no later than 15 days after CVS/caremark receives your claim, regardless of whether the claim is approved or denied, in whole or in part. If your preauthorization claim involves urgent care, a decision will be made and communicated as soon as possible, taking into account the medical urgency, but no later than 72 hours after CVS/caremark receives your claim.

If CVS/caremark needs more information to process your urgent care preauthorization claim, it will notify you verbally, unless you request written notice, no later than 24 hours after it receives your claim. You will have at least 48 hours to provide the requested information. You will be notified of a decision as soon as
possible, but no later than 48 hours after the requested information is received or, if earlier, the end of the deadline for providing the requested information. Because of the urgency of these claims, notice of a decision may be given verbally and followed up in writing no later than three days after the verbal notice.

**Content of Initial Claims Decision**
If any claim is denied, in whole or in part, you will receive written notice of the denial. The written notice will explain:

- Why the claim was denied and refer to the specific Plan provisions on which the denial was based;
- What additional information is needed to have your claim reconsidered on appeal and why the information is needed;
- Any specific rule, guideline, or protocol relied upon in making the decision and how you can get a copy free of charge;
- Any clinical or scientific judgment for the decision if it was based on a medical necessity, experimental treatment, or similar exclusion or limit (or state that such explanation will be provided upon request);
- The Plan’s appeal procedures and time limits, including a statement that you have a right to bring a civil action under Section 502(a) of ERISA after you have made the mandatory appeals; and
- In the case of a preauthorization claim involving urgent care, the Plan’s expedited review process for such claims.

In addition to the above, the notice will include information sufficient for you to identify the claim and information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeals process.

**NOTE:** If a verbal notice is also provided for an urgent care claim, the above information will be provided verbally and followed up in writing.

**PRESCRIPTION DRUG CLAIMS APPEALS AND EXTERNAL REVIEW**
You have the right to two internal appeals after an “adverse benefit determination.” An “adverse benefit determination” is made when you follow the Plan’s claims administration procedures but your claim is denied, in whole or in part, or coverage is terminated retroactively (whether or not there is an adverse effect on any particular benefit). Generally, you are able to pursue a voluntary appeal for external review or civil litigation under Section 502(a) of ERISA only after you have completed the two internal levels of appeal. However, if CVS/caremark does not strictly adhere to all claim determination and appeal procedures under applicable federal law, you are considered to have exhausted the CVS/caremark’s internal appeals process (“Deemed Exhaustion”) and may proceed with external review or pursue any available remedies under Section 502(a) of ERISA. CVS/caremark’s two internal appeals are referred to as a “First Level Appeal” and a “Second Level Appeal.” The following information explains how and when you can make First and Second Level Appeals.

**Internal Claims Appeal Process:**
As a participant in the Plan, if you are not satisfied with the outcome of CVS/caremark’s initial determination, you may appeal CVS/caremark’s decision pertaining to the following matters:

- CVS/caremark’s pre-authorization of outpatient prescription drug expenses;
- Claim payment (after your purchase of your prescription);
Plan interpretation; and
Benefit determination, including retroactive termination of coverage (whether or not there is an adverse
effect on any particular benefit).

First Level Appeal
A “First Level Appeal” is a request from you for a review of the adverse benefit determination. Send your
First Level Appeal to:

Caremark, Inc.
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Phone Number: 1-866-443-1183
Fax Number: 1-866-689-3092

You must make your First Level Appeal, in writing, within 180 days after you receive the claim denial. The
appeal should include:

- The Group name;
- Your name and CVS/caremark ID number;
- The date(s) of your prescription orders or refills;
- The pharmacy’s name;
- The reason you believe the claim should be paid; and
- Any written comments, documentation, records, or other information to support your request for
claim payment (whether or not submitted with your initial claim).

Upon receipt of your First Level Appeal, the Appeals Department at CVS/caremark will make a full and
fair review of your claim, taking into account all information submitted by you (regardless of whether the
information was submitted or considered by CVS/caremark in its initial decision) to determine if the
medication use meets coverage conditions specified or intended by the Plan. CVS/caremark’s review will
not give deference to its prior determination. A qualified individual who was not involved in the decision
being appealed and who is not a subordinate of the individual(s) involved in the prior decision will be
appointed to decide your First Level Appeal. If your First Level Appeal is related to clinical matters, the
review will be done in consultation with a health care professional with appropriate expertise in the field
who was not involved in the prior determination (nor the subordinate of the individual[s] involved in the
prior decision).

Upon request, and free of charge, you will be given reasonable access to, and copies of, all documents,
records, and other information relevant to your claim for a Covered Drug expense, and to the identity of
any medical or pharmaceutical expert consulted in connection with CVS/caremark’s prior determination
(whether or not the expert’s advice was used).

Notification of First Level Appeal Decision
CVS/caremark will provide you with a written notice of its decision within the time frame shown in the
chart that follows (which also includes other important time frames).

Written Decision on First Level Appeal
CVS/caremark will send you written or electronic notification of its decision on your First Level Appeal. If
your First Level Appeal is denied, in whole or in part, the written notice will explain:
• Why the appeal was denied and refer to the specific Plan provision(s) on which the denial was based;
• What additional information is needed to have your claim reconsidered at the next appeal level and why the information is needed;
• Any specific rule, guideline, or protocol relied upon in the adverse benefit determination and how to get a copy free of charge;
• Any clinical or scientific judgment for the decision if it was based on a medical necessity, experimental treatment, or similar exclusion or limit (or state that such explanation will be provided upon request); and
• The Plan’s procedures and time limits for filing a Second Level Appeal, including a statement that you have a right to bring a civil action under Section 502(a) of ERISA after you have made the mandatory appeals.

Second Level Appeal
A “Second Level Appeal” is a request from you for a review of the adverse benefit decision rendered in the First Level Appeal.

If you are dissatisfied with CVS/caremark’s First Level Appeal decision, you may file a “Second Level Appeal” with CVS/caremark.

If you are appealing CVS/caremark’s First Level Appeal decision, you must file your Second Level Appeal, in writing, within 60 days (72 hours for urgent care appeals) of receipt of the First Level Appeal decision.

Send your Second Level Appeal to the same address as your First Level Appeal and include all relevant information you want CVS/caremark to consider.

If requested, you will be given reasonable access to, and copies of, all documents, records, or other information relevant to your claim, free of charge, and the identity of any medical or pharmaceutical expert consulted in connection with the First Level Appeal (regardless of whether the expert’s advice was used to deny your claim).

Upon receipt of your Second Level Appeal, the Appeals Department at CVS/caremark will make a full and fair review of your claim, taking into account all information submitted by you (regardless of whether the information was submitted or considered in the First Level Appeal). The review will not defer to CVS/caremark’s prior decision(s) and will be reviewed by a party independent of those who rejected the First Level Appeal. If CVS/caremark’s denial was based on medical judgment, CVS/caremark will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with its prior decision(s) nor a subordinate of any such person. Before CVS/caremark makes its final decision, if applicable, you will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by CVS/caremark (or at the direction of CVS/caremark), or any or additional rationale as soon as possible and in sufficient time to allow you the opportunity to respond before CVS/caremark issues its Second Level Appeal decision.

Notification of Second Level Appeal Decision
CVS/caremark will provide you with a written notice of its decision within the time frame shown in the chart that follows (which also includes other important time frames).

Written Decision on Second Level Appeal
CVS/caremark will send you written or electronic notification of its decision on your Second Level Appeal. If your Second Level Appeal is denied, in whole or in part, the written notice will explain:

- Why the appeal was denied and refer to the specific Plan provision(s) on which the denial was based;
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- Any specific rule, guideline, or protocol relied upon in the adverse benefit determination and how to get a copy free of charge;
- Any clinical or scientific judgment for the decision if it was based on a medical necessity, experimental treatment, or similar exclusion or limit (or state that such explanation will be provided upon request); and
- The Plan’s voluntary external review process.

The written denial notice will also state that you have the right to either bring a civil action under Section 502(a) of ERISA after the Second Level Appeal or file a voluntary appeal for external review.

**CVS/caremark’s Decisions**

For all prescription appeals, the Plan Administrator has delegated to CVS/caremark the exclusive discretion and authority to interpret and administer the provisions of the Plan to determine on the Plan’s behalf, whether a medication is a covered drug and if an amount charged is considered a usual charge under the Plan.

CVS/caremark’s decision on Second Level Appeals is final, conclusive, and binding under ERISA, unless you request external review or bring civil litigation.

**NOTE:** CVS/caremark’s decision pertains only to whether or not a prescription medication is a covered drug under the Plan. Any decision as to whether you or your covered dependents receive a prescription medication is between you and your doctor and does not involve the Company, the Plan Administrator, or CVS/caremark.

**Summary of Important Deadlines**

Your deadlines for filing an appeal of a denied claim and CVS/caremark’s deadline for responding to your appeals are summarized as follows.

<table>
<thead>
<tr>
<th>Action</th>
<th>Claims Involving Urgent Care</th>
<th>Pre-Service Claims</th>
<th>Post-Service Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making a First Level Appeal of a denied claim</td>
<td>Within 180 days after you receive the claim denial</td>
<td>Within 180 days after you receive the claim denial</td>
<td>Within 180 days after you receive the claim denial</td>
</tr>
<tr>
<td>CVS/caremark’s notification of its First Level Appeal decision</td>
<td>As soon as possible, taking into account the medical urgency, but no later than 36 hours, after CVS/caremark receives your appeal*</td>
<td>Within a reasonable time appropriate to the medical circumstances, but no later than 15 days after CVS/caremark receives your appeal</td>
<td>Within a reasonable time, but no later than 30 days after CVS/caremark receives your appeal</td>
</tr>
</tbody>
</table>
Making a Second Level Appeal after the First Level Appeal is denied

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Within 72 hours after you receive the notice denying your First Level Appeal</td>
</tr>
<tr>
<td>2</td>
<td>Within 60 days after you receive the notice denying your First Level Appeal</td>
</tr>
<tr>
<td>3</td>
<td>Within 60 days after you receive the notice denying your First Level Appeal</td>
</tr>
</tbody>
</table>

CVS/caremark’s notification of its Second Level Appeal decision

As soon as possible, taking into account the medical urgency, but no later than 36 hours) after CVS/caremark receives your appeal*

Within a reasonable time appropriate to the medical circumstances, but no later than 15 days after CVS/caremark receives your appeal

Within a reasonable time, but no later than 30 days after CVS/caremark receives your appeal

* Because of the urgency of these claims, you may receive notice by phone, fax, or e-mail.

Voluntary External Review Process

Request for Independent External Review

You may voluntarily file a request for External Review of any final internal appeal determination that qualifies.

Other than in a case of Deemed Exhaustion, you must complete the First Level Appeal and the Second Level Appeal, as described above, before you can request External Review. Subject to verification procedures that CVS/caremark may establish, your authorized representative may act on your behalf in requesting and pursuing External Review.

You may request External Review for any initial determination (e.g., Explanation of Benefits [EOB]) or any final review that qualifies as set forth below. The written notice you receive regarding CVS/caremark’s initial determination or its decision on your Second Level Appeal will describe the process to follow if you wish to request an External Review.

You must submit your Request for External Review to CVS/caremark within four months after you receive notice of CVS/caremark’s initial determination or decision on your Second Level Appeal. You also must include a copy of CVS/caremark’s notice, your name, contact information (mailing address and daytime telephone number), member ID number, and all other pertinent information that supports your request for External Review. Mail or fax this information into:

CVS/caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-689-3092

If you request External Review, any applicable statute of limitations will be tolled while the External Review is pending. Requesting External Review will have no effect on your rights to any other benefits under the Plan. External Review is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to request External Review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

External Review Process

CVS/caremark’s External Review process gives you the opportunity to have a review of CVS/caremark’s initial determination, including its decision on your Second Level Appeal, conducted pursuant to applicable federal law. Your request will be eligible for External Review if one of the following is satisfied:
CVS/caremark does not strictly adhere to all claim determination and appeal requirements under applicable federal law;

First Level Appeal and Second Level Appeal have been exhausted; and

The appeal relates to a rescission, i.e., cancellation or discontinuance of coverage which has retroactive effect.

A denial of coverage based upon your eligibility for Plan participation (e.g., work classification or similar determinations) is not eligible for External Review.

If upon the Second Level Appeal, CVS/caremark upholds the coverage denial and it is determined that you are eligible for External Review, you will be informed, in writing, of the steps necessary to request External Review.

**Preliminary Review**

Within five (5) business days after CVS/caremark receives your Request for External Review, it will conduct a preliminary review to determine the following: you were covered under the Health Plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, was covered at the time the prescription drug was provided; the determination does not relate to eligibility for Plan participation, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all information and forms necessary to process the External Review.

Within one business day after completion of the preliminary review, CVS/caremark will notify you, in writing, that:

- The request for External Review is complete and may proceed;
- The request for External Review is complete but not eligible for External Review:
  - The reasons for its ineligibility, and
  - Contact information for the Employee Benefits Security Administration (toll-free number at 1-866-444-EBSA (1-866-444-3272); or
- The Request for External Review is not complete:
  - Describe the information or materials needed to make the request complete, and
  - Give you until the later of the four-month filing period, or 48 hour period after you receive the notice, to submit the information or materials.

**Referral to Independent Review Organization (IRO)**

An Independent Review Organization (IRO) refers the case for review by a neutral, independent medical or pharmaceutical expert with appropriate expertise in the area in question. The decision of the independent external reviewer is binding on you, CVS/caremark, and the Plan.

If CVS/caremark determines that the Request for External Review is eligible for External Review, CVS/caremark will assign an IRO, accredited as required under federal law, to conduct the External Review. The assigned IRO will timely notify you in writing of the request’s eligibility and acceptance for External Review and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the IRO must consider when conducting the External Review. Within five business days after its assignment to the IRO, CVS/caremark will provide the IRO with all documents and information that CVS/caremark considered in making its initial determination or decision on your Level II appeal. If CVS/caremark fails to provide the documents within the five-day period, the IRO may unilaterally terminate External Review and make a decision to reverse CVS/caremark’s coverage decision. If the IRO makes the decision to terminate External Review, the IRO will, within one business day of making its decision, notify you, CVS/caremark, and the Plan.
The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim and not be bound by any decisions or conclusions reached during CVS/caremark’s internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

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

The assigned IRO will provide written notice of its Final External Review Decision within 45 days after receiving the Request for External Review. The IRO will deliver its Final External Review Decision to you, CVS/caremark and the Plan.

The IRO’s notice will contain:

- A general description of the reason for the Request for External Review, including information sufficient to identify the claim (e.g., the date or dates of service, the health care provider, the claim amount [if available], the diagnosis code and its meaning, the treatment code and its meaning, and the reasons for the previous denials);
- The date the IRO received the External Review assignment from CVS/caremark and the date of the IRO’s decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;
- A discussion of the principal reason(s) for the IRO’s decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or you;
- A statement that you may still be eligible to seek judicial review of any adverse External Review determination; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist you.

If the IRO’s Final External Review Decision reverses CVS/caremark’s initial determination or Second Level Appeal decision, CVS/caremark will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

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

**Expedited External Review Process**

You may request an expedited External Review upon receiving:

- An initial determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- A Second Level Appeal decision, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Second Level Appeal decision concerns an admission, availability of care, continued stay, or a prescription drug benefit for which you received emergency services, but have not been discharged from a facility.

**Request for Expedited External Review**

To request an expedited External Review, call the Customer Care toll-free at the number on your CVS/caremark ID card or, alternatively, fax your information to the attention of the CVS/caremark External Review Appeals Department at 1-866-689-3092. Your request should include your name, contact information (mailing address and daytime telephone number), member ID number, a description of the coverage denial, and other pertinent information that supports your request for an expedited External Review. All requests for expedited External Reviews must be clearly identified as “urgent” at submission.

**Preliminary Review**

Immediately upon receipt of the request for an expedited External Review, CVS/caremark will conduct the Preliminary Review described above for a standard External Review. CVS/caremark will immediately send you a notice of its determination.

**Referral to Independent Review Organization (IRO) for Expedited Review**

If CVS/caremark determines that the request for an expedited External Review is eligible for an expedited External Review, CVS/caremark will assign an IRO. CVS/caremark will provide or transmit all necessary documents and information considered in making its initial determination or its Second Level Appeal decision to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method. The IRO will review the information and documents described above for standard External Review and will render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing the notice, the IRO will provide written confirmation of the decision to you, CVS/caremark, and the Plan. If the IRO’s decision reverses CVS/caremark’s initial determination or Second Level Appeal decision, CVS/caremark will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

After its decision, the IRO will maintain records of all claims and notices associated with the expedited External Review process for six years. An IRO will make such records available for examination by you, the Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.
EVENTS THAT MAY AFFECT PLAN COVERAGE

WHEN COVERAGE ENDS
When your coverage ends for any reason, your dependent’s coverage ends automatically. Your and/or your dependent’s coverage under the Plan ends on the earliest of the following events:

- The Friday coinciding with or following the date of your termination of employment;
- The Friday coinciding with or following the date of you are no longer eligible for coverage;
- Your paid-through date of coverage if you are being cancelled for non-payment of premiums;
- If you pay for benefits on an after-tax basis, the Friday coinciding with or following the date you make the request to cancel coverage;
- If you pay for benefits on a before-tax basis, and there is no qualifying life event, the earliest you can cancel your benefits is during the next Annual Enrollment period;
- The last day of the month in which your dependent child is no longer eligible for coverage due to reaching age 26;
- The date the Plan is terminated;
- The Friday coinciding with or following the date of your death;
- The Friday following the date you notify the myHR Service Center of your divorce, legal separation, or annulment;
- The Friday following or coinciding with the date you notify the myHR Service Center that your domestic partner and/or your domestic partner’s eligible children no longer meet eligibility requirements;
- The date determined by the Plan Administrator, if you (or your covered dependent[s]) intentionally commit a fraudulent act for purposes of obtaining coverage or filing claims, or allow someone else to use your coverage;
- The date you (or your covered dependent[s]) engage in serious misconduct; or
- The date your address is changed and you no longer reside in the Plan’s service area.

NOTE: If you do not reside in the Plan’s service area, your coverage will end on the date your address is updated in the myHR records.

If you leave the Company or retire, you and your covered dependents may be able to continue coverage under a Company-sponsored plan. For additional information, see the COBRA Continuation Coverage section.

TERMINATION OF EMPLOYMENT
Coverage for you and your covered dependents ends at midnight on the Friday coinciding with or following the date of your termination of employment. Coverage cannot be extended by paid leave (vacation, sick pay, or Paid Time Off [PTO]) or severance paid after your termination of employment.
LEAVE OF ABSENCE
Your coverage may continue for the duration of your approved leave of absence, up to a maximum of 24 months, provided you pay the required contributions. If you do not pay the required contributions, coverage ends for you and your covered dependents on the last paid-through coverage date. See “Payment Process” in the Your Health Plan Contributions section for more information.

If you terminate employment by not returning to work on schedule or by notifying your manager that you are not returning to work, coverage ends on the Friday coinciding with or following the last day of your approved leave of absence or the Friday coinciding with or following the date you notify the manager that you are not returning to work, whichever is applicable, provided your contributions are paid up to date in full at the time of termination.

See “Reinstating Coverage Following an FMLA or Military Leave of Absence” in the Your Health Plan Contributions section for more information.

FAILURE TO PAY CONTRIBUTIONS
If you do not send the myHR Service Center the total amount requested on your bill by the due date, coverage ends for you and your covered dependents on your last paid-through coverage date.

LEGAL SEPARATION, ANNULMENT, OR DIVORCE
If you get divorced or legally separated, or your marriage is annulled, you must cancel your spouse’s coverage within 31 days of the event since he or she is no longer an eligible dependent. You must also remove stepchildren from coverage at that time.

You may cancel coverage by using the myHR Web site or by calling the myHR Service Center. Coverage ends on the Friday coinciding with or following the date of notification of the date of the divorce, the date of the legal separation, or the date of the annulment.

You may be required to provide legal evidence of the event. You may not receive a refund of the premiums paid on your covered spouse’s behalf prior to the myHR Service Center’s receipt of your notice of the event.

If you do not timely cancel your spouse’s coverage, you will be responsible for repaying the Plan for any benefits that are paid on behalf of your spouse (and his or her covered children) after the date of divorce, legal separation, or annulment, whichever occurs first.

NOTE: If you do not contact the myHR Service Center within 60 days of the date of your divorce, legal separation, or annulment, your spouse (and his or her covered children) will not receive COBRA continuation coverage notification and, therefore, may not be eligible to continue Plan coverage.

See the COBRA Continuation Coverage section.

DISSOLUTION OF DOMESTIC PARTNERSHIP
If your domestic partnership is dissolved, you must cancel your domestic partner’s coverage within 60 days of the event since he or she is no longer eligible for Plan coverage. You must also remove your domestic partner’s children from coverage at that time.

You may cancel coverage by using the myHR Web site or by calling the myHR Service Center. Coverage ends on the Friday coinciding with or following the date of notification of the dissolution of the domestic partnership.

You may be required to provide documentation supporting the dissolution of your domestic partnership. You may not receive a refund of the premiums paid on your covered partner’s behalf prior to the myHR Service Center’s receipt of your notice of the event.
If you do not timely cancel your domestic partner coverage, you will be responsible for repaying the Plan for any benefits that are paid on behalf of your domestic partner (and his or her covered children) after the date of dissolution of the domestic partnership.

**NOTE:** If you do not contact the myHR Service Center within 60 days of the date of the dissolution of the domestic partnership, your domestic partner (and his or her covered children) will not receive COBRA continuation coverage notification and, therefore, may not be eligible to continue Plan coverage. See the COBRA Continuation Coverage section.

**LOSS OF DEPENDENT STATUS**
If your covered child becomes ineligible for Plan coverage, you must cancel your child’s coverage within 60 days of the event since he or she is no longer an eligible dependent.

You may cancel coverage by using the myHR Web site or by calling the myHR Service Center. Coverage ends on the last day of the month in which your dependent child loses eligibility.

You may not receive a refund of the premiums paid on your covered child’s behalf prior to the myHR Service Center’s receipt of your notice of the event.

If you do not timely cancel your child’s coverage, you will be responsible for repaying the Plan for any benefits that are paid on behalf of your child after the date he or she loses dependent status.

**NOTE:** If you do not contact the myHR Service Center within 60 days of the date your dependent child loses Plan eligibility, your dependent child will not receive COBRA continuation coverage notification and, therefore, may not be eligible to continue Plan coverage. See the COBRA Continuation Coverage section.

**CHANGE OF ADDRESS**
Moving to a new, permanent address may allow you to make changes to your medical plan coverage mid-year.

1. If your current Aetna medical plan is offered at your new address, you will not be allowed to change your medical plan until Annual Enrollment.

2. If your current Aetna medical plan is not offered at your new address, you will be automatically enrolled in the PPO/POS medical plan available in your new ZIP code when your address change is processed on the myHR website. You will receive a Confirmation Notice in the mail that provides information on your new PPO/POS coverage and how to select from other medical plan options in your new area. You will be given 31 days to make a new election by contacting the myHR service center. If a new election is made, the coverage and costs for the new plan will be effective on the Saturday following the date of the election.

3. If you are not enrolled in a medical plan, your address change will not allow you to add coverage. You will need to wait until Annual Enrollment.

If your new plan is under the same provider (Aetna) as the plan you were in prior to your address change, then your in-network deductible and out-of-pocket-limit will transfer to the new plan. If your new plan is under a different provider, your deductible and out-of-pocket-limit will start over with the new plan.

**REQUEST TO CANCEL**
If your contributions are being made on an after-tax basis, you may cancel your coverage (or remove a dependent from your coverage) at any time during the Plan Year. You may cancel coverage by using the...
myHR Web site or by calling the myHR Service Center. Coverage ends on the Friday coinciding with or following the date you make the request to cancel coverage.

If your contributions are being made on a before-tax basis, you may not cancel your coverage (or remove a dependent from your coverage) until the end of the Plan Year (during the annual enrollment period for the next Plan Year), unless you have a qualified life event (see “Qualified Life Events” in the Enrollment section). For a qualified life event, coverage ends on the date of the qualified event.

If participation in the Plan ends, but contributions are still being deducted from your paycheck, you should call the myHR Service Center immediately. Erroneous contributions will not entitle you to extend coverage under the Plan.

**NOTE:** If you voluntarily cancel your coverage and later wish to re-enroll, you and/or your dependents, as applicable, will be considered late enrollees (see “Late Enrollees” in the Enrollment section) and will not be able to re-enroll until the next annual enrollment period, unless you have a qualified life event (see “Qualified Life Events” in the Enrollment section) or were on an FMLA or military leave (see “Reinstating Coverage Following an FMLA or Military Leave of Absence” in the Your Health Plan Contributions section) when you voluntarily cancelled coverage. Also, if you voluntarily cancel coverage, you and/or your dependents, as applicable, will not be eligible for COBRA continuation coverage. See the COBRA Continuation Coverage section.

**INELEGIBILITY TO PARTICIPATE**

If, for any reason other than those stated in this section, you and/or your dependent(s) becomes ineligible to participate in the Plan, coverage for you and/or your dependent(s) ends on the Friday coinciding with or following the date eligibility is lost.

**DEATH**

If you die, COBRA continuation coverage will be provided to your covered dependent(s) for up to 36 months. The first two months of coverage will be at no cost to your dependent(s). After the first two months, they may continue COBRA continuation coverage for up to the remaining 34 months by paying the required premium payments. For additional information, see the COBRA Continuation Coverage section.

**FRAUDULENT ACT/SERIOUS MISCONDUCT**

If you or one of your covered dependents intentionally:

- Permits any non-covered person to use Plan coverage,
- Furnishes incorrect or misleading information when filing a claim,
- Furnishes incorrect or misleading information in a statement made for the purpose of obtaining coverage, or
- Engages in serious misconduct (including, but not limited to, harassing, intimidating, or threatening behavior, whether verbally or in writing) with respect to the Plan or any of its representatives or vendors,

the Plan Administrator has the authority to cancel all Company-sponsored plan coverage, and to make you ineligible to participate in any Company-sponsored plan. If this action is taken, you will be given written notice that your coverage is cancelled effective on the date specified in the written notice, and you will no longer be covered under the Plan. In addition, civil and/or criminal penalties can result from these acts.

Requests for Medical Benefits for medical expenses related to illness or injuries incurred in the commission of a crime, whether a misdemeanor or felony, shall not be Covered Expenses.
NOTE: Plan coverage may be cancelled retroactively if you or a covered dependent performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the Plan. If Plan coverage is going to be cancelled retroactively, you will be provided with a written notice at least 30 days in advance of the cancellation.

TERMINATION OF THE PLAN
Coverage ends on the date, if any, when the Plan itself is terminated.

CONTINUING YOUR COVERAGE
Under certain circumstances, you and your covered dependents may be able to continue coverage beyond the date coverage would otherwise end. For additional information, see the COBRA Continuation Coverage section.

HOW TO FILE A CLAIM

(See the Prescription Drugs section for information about how to file a pharmacy claim.)

HOW TO FILE A CLAIM FOR PLAN BENEFITS
A claim for benefits is any request for benefits from the Plan made in accordance with these claims procedures. Any other request for benefits, including any communications regarding benefits that are not made in accordance with these claims procedures, will not be treated as a claim for benefits.

AUTHORIZED REPRESENTATIVE
You may have an authorized representative (including a treating health care professional) act on your behalf with respect to a benefit claim or appeal by notifying Aetna in writing. Aetna will recognize a court order giving a person authority to submit claims on your behalf. Aetna may also recognize other providers as authorized to act on your behalf under its procedures.

In the case of an urgent care claim, Aetna will automatically recognize a health care professional with knowledge of your medical condition (for example, the treating physician) as your authorized representative, unless you give Aetna other instructions in writing.

Once you have an authorized representative, the Plan will direct all information, notification, etc., regarding your claim to the authorized representative. You will receive copies of all notifications regarding decisions, unless you give the Plan other instructions in writing.

NOTE: Once you have an authorized representative, all references in these claims procedures to you will include your authorized representative, where appropriate.

Also note that an assignment for payment (for example, to a health care professional) does not constitute an appointment of an authorized representative under these claims procedures.
FILING A CLAIM
There are four types of claims, each with different time limits. The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claim procedures, it may be recharacterized. For example, a claim may initially be an urgent care claim. However, if the urgency subsides, it may be recharacterized as a pre-service claim.

Pre-Service Claims (Other Than Urgent Care Claims)
This is a claim for benefits from the Plan where the Plan requires that, to receive benefits from the Plan, in whole or in part, you must obtain approval before you receive the medical care. Benefits from the Plan that specifically require advanced approval are discussed in “Precertification” in the How the Health Plan Works section.

You must file a pre-service claim in accordance with the instructions in “Precertification,” including providing all required information. If your pre-service claim is incorrectly filed, you will be notified. See “Notifications” later in this section.

Urgent Care Claims
This is a pre-service claim for medical care or treatment that, if not decided quickly, could seriously jeopardize your life or health or ability to regain maximum function or would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

When Aetna receives a pre-service claim, it will decide whether it involves urgent care. A person acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will make this determination. However, if a physician with knowledge of your medical condition tells Aetna that your claim involves urgent care, Aetna will treat your pre-service claim as an urgent care claim.

You must file an urgent care claim in accordance with the instructions in “Precertification” in the How the Health Plan Works section, including providing all required information, and should include the reason why your claim should be processed on an expedited basis. If you do not follow the correct procedures for filing an urgent care claim, you will be notified. See “Notifications” later in this section.

(For concurrent care claims involving urgent care, see “Concurrent Care Claims” below.)

Post-Service Claims
A post-service claim is a claim for benefits from the Plan after you have received medical care.

Claims filed 24 months or more after the date of service will not be paid unless you have proof of timely filing.

Generally, you do not need to file a claim when you use a network provider. The network provider will file the claim for you. If you use an out-of-network provider, you must file your own claim.

Concurrent Care Claims
The Plan makes a concurrent care decision when it approves an ongoing course of treatment to be provided over a period of time (for example, 15 weeks of physical therapy) or for a specified number of treatments (for example, 10 outpatient substance abuse treatments).

If you have been approved for an ongoing course of treatment, you will be notified in advance if the approved course of treatment is intended to be terminated or reduced. You will be provided with the notice in sufficient time to allow you the opportunity to appeal the decision and receive a decision on your appeal before the termination or reduction takes effect.

If you would like to extend an ongoing course of treatment that is a claim involving urgent care, a claim for such extension should be filed at least 24 hours before the end of the initially approved period of time or number of treatments.
Submitting a Claim

To submit an urgent care claim (including a concurrent care claim involving urgent care), you may call Member Services at 1-877-706-8776. Follow the instructions in this section and provide all required information.

To obtain claim forms for out-of-network claims, call Member Services or access the Forms section on Aetna’s Web site. Mail a completed claim form and itemized bill for payment to:

Aetna
P.O. Box 14079
Lexington, KY 40512-4079

Keep a copy of your paperwork for your records. All benefits from the Plan for a network provider will be paid directly to the provider.

NOTIFICATIONS

Incorrectly Filed Pre-Service (Including Urgent Care) Claims
If you do not follow the correct procedures for filing a pre-service claim (including an urgent care claim), Aetna will notify you as soon as possible, but no later than five days after it receives the incorrectly filed pre-service claim and no later than 24 hours after it receives the incorrectly filed urgent care claim. The notification may be in writing or verbal (unless you specifically request written notification) and will describe the proper procedures for filing the claim.

Notice of Initial Claims Decision
You will receive a written decision from Aetna regarding your claim as follows:

Urgent Care Claims
For an urgent care claim, you will receive a decision as soon as possible, taking into account the medical urgency, but no later than 24 hours after Aetna receives your claim, regardless of whether the claim is approved or denied, in whole or in part. If it is determined that additional information is needed to process your claim, you will be notified (verbally, unless you request written notice) and told the specific information needed no later than 24 hours after Aetna receives your claim. You will have at least 48 hours to provide the requested information. You will be notified of a decision as soon as possible, but no later than 48 hours after the requested information is received or, if earlier, the end of the deadline for providing the requested information. Because of the urgency of these claims, notice of a decision may be given verbally and followed up in writing no later than three days after the verbal notice.

Pre-Service Claims and Post-Service Claims
For a pre-service claim, you will receive a decision within a reasonable time appropriate to the medical circumstances, but no later than 15 days after Aetna receives your claim (unless Aetna extends the deadline), regardless of whether the claim is approved or denied, in whole or in part.

For a post-service claim, you will receive a decision within a reasonable time, but no later than 30 days after Aetna receives your claim (unless Aetna extends the deadline), if the claim is denied, in whole or in part.

If Aetna needs more time to process a pre-service claim or a post-service claim because of matters beyond the Plan’s control, it may extend the initial period (15 days for a pre-service claim or 30 days for a post-service claim) for up to an additional 15 days by notifying you of the extension before the end of the initial period. The extension notice will explain the reason for the extension; the date the decision is expected to be made; and, if the extension is needed because you did not submit information necessary to process your claim, the additional information needed. If you are requested to provide additional information to process your claim, you will have at least 45 days to provide the information. The days from the date you are sent the extension notice to the due date for the requested information...
(or, if earlier, the date you respond to the request) are not counted as part of the time period by which Aetna must make a decision.

**Concurrent Care Claims**

For a claim to extend an ongoing course of treatment that is a claim involving urgent care, you will receive a decision as soon as possible, taking into account the medical urgency, but no later than 24 hours after Aetna receives your claim, regardless of whether the claim is approved or denied, in whole or in part, provided you file the claim at least 24 hours before the end of the initially approved period of time or number of treatments.

Any other request to extend an ongoing course of treatment will be decided according to the applicable time limits for urgent care claims, pre-service claims, and post-service claims.

**NOTE:** If you do not hear from Aetna in the expected time period, call Member Services to make sure your claim was received.

**Content of Initial Claims Decision**

If your urgent care claim or pre-service claim is approved, in whole or in part, you will receive written notice of its approval.

If any claim is denied, in whole or in part, the written notice will explain why the claim was denied and refer to the specific Plan provisions on which the denial was based; what additional information is needed in order to have your claim reconsidered on appeal and why the information is needed; if applicable, any internal rules, guidelines, protocols, or similar criteria that were relied upon in making the decision (or state that such rules, etc., were relied upon and how you can get a copy free of charge); if applicable, the clinical or scientific judgment for the decision if it was based on a medical necessity, Experimental Treatment, or similar exclusion or limit (or state that such explanation will be provided upon request); the Plan’s appeal procedures and time limits, including a statement that you have a right to bring a civil action under section 502(a) of ERISA after you have made the mandatory appeals. In addition to the above, the notice will include information sufficient for you to identify the claim and information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeals process.

**NOTE:** If a verbal notice is also provided for an urgent care claim, the above information will be provided verbally and followed up in writing.

**CLAIM PAYMENT ERRORS**

If benefit payments to you or on your behalf are greater than the amount that should have been paid, the Plan Administrator and Aetna have the right and obligation to recover the excess amount.

If any excess payments cannot be recovered from you or the provider, the Plan Administrator and Aetna have the right to reduce or offset future payments that might otherwise be payable to you or your covered dependents. They also have the right to take appropriate legal action to recover erroneous payments, including payments that should have been made by a plan that was primary to the Plan.

If you believe a claim was processed incorrectly, you may file an appeal. See the *Your Appeal Rights* section.

**COORDINATING WITH OTHER PLANS**

**NON-DUPLICATION OF BENEFITS**

If you and your spouse or domestic partner both work, your family may be covered by more than one group health plan. The Plan coordinates its payments with the payments you may receive from other group
insurance plans under which you or your dependents are covered. The following types of plans are coordinated with your Plan coverage:

- Group insurance through your spouse’s employer;
- Group insurance through a professional or fraternal association;
- Motor vehicle insurance (your own or any other responsible party’s); and
- Other group insurance plans to which you or your dependents belong.

**NOTE:** The Plan does not coordinate payments with individual medical insurance.

### HOW TO DETERMINE WHICH PLAN IS PRIMARY

In general, the Plan will be considered primary for:

- Employees; and
- Covered dependents when the employee’s birthday falls before his or her spouse’s birthday (month and day, not year) in a calendar year.

**The Birthday Rule**

If both parents have the same birthday, the plan that covered the parent for a longer time will be primary. If the other plan has not adopted this birthday rule, the plan of the father will be primary to the plan of the mother.

**If You Are Divorced or Separated**

If the parents are divorced or legally separated, the following determines primary/secondary payment responsibilities for the dependent child:

1. The plan of the parent with financial responsibility for the child’s health care expenses by court decree pays first; any other plan that covers the child as a dependent pays second.
2. If there is no court decree and the parent with custody of the child has not remarried, the plan of the parent with custody of the child pays first; the plan of the parent without custody pays second.
3. If there is no court decree and the parent with custody of the child has remarried, the plan of the parent with custody of the child pays first; the stepparent’s plan pays second; and the plan of the parent without custody pays last.

**The Other Plan Is Automatically Primary**

Any other plan will be primary if it:

- Does not have a coordination of benefits or non-duplication of benefits provision;
- Is a program required or provided by law; or
- Is a motor vehicle insurance policy. (In certain states, the motor vehicle insurance policy allows you to designate your group plan as primary. If this applies to you, you must submit written proof to Aetna that you have designated the Plan as primary.)

**NOTE:** If none of the rules above apply, the plan that has covered the participant for the longer period of time will be primary.
HOW THE PLAN PAYS BENEFITS

If the Plan is primary, it will pay benefits without regard to the secondary plan’s benefits. The Plan will consider the charges first.

If the Plan is secondary, benefits will be determined as follows:

- If the amount you are entitled to receive from all other coverages is the same as or greater than what the Plan would have paid if it had been the only coverage, the Plan will not pay any benefits.

- If the amount you are entitled to receive from all other coverages is less than what the Plan would have paid if it had been the only coverage, the Plan will pay benefits. Payments will be calculated as if the Plan was primary and then reduced by the benefits you are entitled to receive from the other plans.

Example: Suppose you and your spouse both have family coverage through your respective employers. Your spouse goes to an in-network Plan primary care Provider, and the bill for the office visit is $40. His or her plan pays $32, leaving a balance of $8. If the Plan had been the only coverage, the Plan would have paid $40 minus the $25 Co-Pay for this service, or $15. Since this amount ($15) is less than the benefit paid by the other plan ($32), the Plan would pay no benefit.

Suppose, however, that the cost for the office visit is $100, and your spouse’s plan pays $50—leaving a balance of $50. If the Plan had been the only coverage, the Plan would have paid $100 minus the $25 Co-Pay for this service, or $75. Since this amount ($75) is greater than the benefit paid by the other plan ($50), the Plan would pay $25 ($75 - $50 = $25).

Coordination With Medicaid

For Medicaid participants, charges covered by the Plan will be paid according to any assignment of rights required by Medicaid. Unless otherwise permitted by law, payments of charges covered under the Plan will be made in the same manner and amount as payment would be made to a participant who is not covered by Medicaid.

NOTE: If either you or a dependent covered by the Plan is entitled to Medicare, see “How the Plan Works With Medicare” in the Medicare Benefits section for coverage information.

HOW TO FILE CLAIMS UNDER TWO PLANS

If you have a situation where benefits are payable under two plans, first file claims with the primary plan. After you receive an Explanation of Benefits (EOB) statement from the primary plan’s insurance carrier, submit the claim and EOB statement to the secondary plan’s insurance carrier.

THIRD-PARTY LIABILITY

If you or one of your covered dependents incurs medical expenses as a result of an injury, illness, or condition for which another party may be liable, the Plan is entitled to recover the costs of any Plan benefits it has provided related to that injury, illness, or condition. The Plan does not intend to provide payment for any medical expenses paid or payable by a third party.

If you or one of your covered dependents incurs medical expenses as a result of an injury, illness, or condition for which another party may be liable, Plan benefits will be paid as an advance payment of such benefits. Any third-party payment(s) for expenses paid by the Plan will be the property of the Plan and, if paid directly to you (or your agent, attorney, or beneficiary), will be held in trust for the benefit of the Plan, up to the amount paid by the Plan. If such third-party payments are not sent to the Plan, you (or other party converting the funds to its own benefit) will be considered to have been unjustly enriched. The failure to send such funds to the Plan will create a constructive trust over the funds and will subject you or the other constructive trustee to an equitable action by the Plan for disgorgement (among other available remedies).
Example of Third-Party Liability
Suppose you are injured in a car accident that is not your fault and receive benefits under the Plan to treat your injuries. Under third-party recovery, the Plan would have the right to take legal action, in your name, against the insurance carrier of the other driver to recover the cost of the covered medical services provided to you. This also means that if you received a settlement from the insurance company, you would have to reimburse the Plan for the amount of Plan benefits it paid to cover your related medical expenses.

By enrolling in the Plan, you (and your covered dependent[s]) agree you will:

• Notify the Plan Administrator (or its designee), in writing, of any legal or administrative proceeding or any negotiations that could result in third-party payments for injuries, illnesses, or conditions for which Plan benefits were paid or are payable;

• Notify the Plan Administrator (or its designee), in writing, of any potential legal claim(s) you may have against any third party resulting from acts that caused Plan benefits to be paid or incurred;

• Transfer your rights to recover damages and/or settlement awards in full to the Plan for medical expenses for which another party(ies) may be liable to the Plan;

• Permit the Plan to act on your behalf to collect these damages and/or settlements from the other party;

• Have no legal or equitable title to funds received from the other party as payment for costs and expenses paid or payable by the Plan, and you will hold such funds in trust for the Plan (as they are the property of the Plan and will be sent to the Plan upon collection); and

• Provide the Plan Administrator (or its designee) with whatever assistance is necessary to restore Plan payments, including providing any information and executing any requisite documents (including documents to transfer title) required by the Plan Administrator (or its designee), in its sole and absolute discretion.

The Plan’s right of full recovery either through subrogation and/or reimbursement for medical expenses for which another party(ies) may be liable may be from any source of payment, including, but not limited to:

• Any judgment, settlement, or other payment made or to be made by or on behalf of the other party(ies);

• Any liability or other insurance coverage;

• Your or your covered dependent’s own uninsured or under-insured motorist coverage;

• Any medical payments; or

• Any no-fault or school insurance coverages that are paid or payable.

The amount due from the other party(ies) will be applied to medical benefits provided under the Plan first, regardless of whether the amount is designated as payment for medical expenses. The Plan will be reimbursed in full, regardless of whether you have been made whole, before any amounts (including attorney’s fees and court costs) are deducted from such payments. You are solely responsible for paying any attorney’s fees or other legal costs that you incur in obtaining any recovery and the Plan’s right to recover the benefits it has paid is not subject to reduction for attorney’s fees or other expenses of recovery.

If the Plan is not reimbursed in full by a third party determined to be responsible for your Plan benefits, the Plan reserves the right to deduct any outstanding amounts from future medical benefit payments.

The Plan may administer this provision through any appropriate method, means, or source it deems appropriate.
**MEDICARE BENEFITS**

**WHAT MEDICARE IS**
Medicare is a federal health insurance program for people age 65 or older, some disabled people under age 65, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Medicare has three parts:

- Part A (Hospital Insurance);
- Part B (Medical Insurance); and
- Part D (Prescription Drug Benefit).

**Part A (Hospital Insurance)**
Medicare Part A helps pay for care in Hospitals as an inpatient, critical access Hospitals (small facilities that give limited outpatient and inpatient services to people in rural areas), and Skilled Nursing Facilities; Hospice care; and some home health care.

**Part B (Medical Insurance)**
Medicare Part B helps pay for doctors’ services, outpatient Hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are Medically Necessary.

**Part D (Prescription Drug Insurance)**
Medicare Part D helps pay for outpatient Generic and Brand-Name prescription drugs.

**FOR MORE INFORMATION ON MEDICARE**
Visit your local Social Security office, or call the Social Security Administration at **1-800-772-1213**. Also, you can visit the Medicare Web site at [www.medicare.gov](http://www.medicare.gov).

**HOW THE PLAN WORKS WITH MEDICARE**
The Plan coordinates its benefits with Medicare for those employees (or covered dependents) entitled to Medicare. Typically, you are considered entitled to Medicare once you are eligible for Medicare (reach age 65) and, if a premium is required for Medicare coverage, you have paid the required premium.

**If You Are an Active, Full-Time Employee**
If you are an active, full-time employee enrolled in the Plan and you (or a covered dependent) are eligible for Medicare, you have the following coverage options:

- Plan coverage only;
- Plan and Medicare coverage; or
- Medicare coverage only.
If you are an active, full-time employee and have both the Plan and Medicare coverage because of age, the Plan coverage is considered primary, i.e., the Plan pays up to the limits of its coverage.

If you are an active, full-time employee and your covered spouse or domestic partner is eligible for Medicare coverage because of age, the Plan coverage is primary for the spouse and Medicare is primary for the domestic partner. This applies even if the domestic partner has not enrolled in Medicare.

If you are an active, full-time employee and your spouse or child has both the Plan and Medicare coverage the Plan coverage is considered primary, i.e., the Plan pays up to the limits of its coverage, and Medicare is considered secondary, i.e., Medicare pays what the Plan does not pay up to the Medicare-approved amount.

If your domestic partner is entitled to Medicare coverage, the Plan coverage is considered secondary to Medicare Part A or Part B even if Medicare coverage does not exist. This means the Plan only pays if there are covered costs Medicare Part A or Part B would not cover (regardless if your domestic partner is enrolled in Medicare Part A or Part B.

Please note that for End-Stage Renal Disease, the Plan will pay primary for the Medicare beneficiary who is eligible for Medicare only during the first 30 months of such eligibility for Medicare benefits. This provision does not apply if, at the start of eligibility, you were already eligible for Medicare benefits, and the Plan’s benefits were payable on a secondary basis.

When Your Employment Terminates
If you have both the Plan and Medicare coverage before your employment terminates or your hours are reduced, you can elect COBRA continuation coverage under the Plan for up to 18 months from the date your employment ends. Medicare, however, will be considered primary and the Plan will be considered secondary. In addition, your covered dependents will be eligible for COBRA continuation coverage for the greater of 36 months from your Medicare entitlement date or 18 months from the date your employment ends or your hours are reduced.

If you first become entitled to Medicare after electing COBRA continuation coverage, you will need to contact the myHR Service Center to cancel your COBRA continuation coverage. Your COBRA continuation coverage will end as of your Medicare entitlement date. However, your covered dependents who are not entitled to Medicare will be eligible for COBRA continuation coverage for up to 36 months from the date your employment ends or your hours are reduced.

You should provide a copy of your Medicare entitlement letter to the myHR Service Center before the 18-month COBRA continuation coverage period ends.

<table>
<thead>
<tr>
<th>If you lose your medical coverage because you leave the Company or your hours are reduced to part-time, temporary, or pool status and:</th>
<th>Then:</th>
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</thead>
<tbody>
<tr>
<td>You (or your covered dependent) were entitled to Medicare before coverage ended or become entitled to Medicare before electing COBRA continuation coverage</td>
<td>You (or your covered dependent) are eligible for COBRA continuation coverage (if you meet all other eligibility requirements).</td>
</tr>
<tr>
<td>You become entitled to Medicare after you have elected COBRA continuation coverage</td>
<td>You are ineligible to continue your COBRA continuation coverage. However, your covered dependents may continue COBRA continuation coverage.</td>
</tr>
<tr>
<td>Your covered dependent becomes entitled to Medicare after COBRA continuation coverage is elected</td>
<td>Your dependent is ineligible to continue COBRA continuation coverage.</td>
</tr>
</tbody>
</table>
YOUR APPEAL RIGHTS

(See the Prescription Drugs section for information about how to file a prescription drug appeal.)

ASSOCIATE ELIGIBILITY/PARTICIPATION APPEALS
If you believe that your request to participate in the Plan has been administered incorrectly, call the myHR Service Center at 1-888-884-6947 (1-888-884-6947) to speak with a myHR Service Center Representative.

The myHR Service Center Representative will discuss your eligibility and/or participation issue with you and make a determination. If you disagree with the myHR Service Center Representative’s determination, you will be transferred to the myHR Service Center Manager for additional assistance. If you disagree with the Manager’s determination, you may appeal the eligibility and/or participation issues up to two levels. The appeals process is described below.

Level I Eligibility/Participation Appeal
To file a first level review of the myHR Service Center Manager’s determination, you must request a Level I Eligibility/Participation Appeal Form from the Manager.

Upon request, the Manager will mail you a Level I Eligibility/Participation Appeal Form within three business days.

You must send the completed and signed Level I Eligibility/Participation Appeal Form and copies of any documents or records that support your request to:

Benefit Determination Review Team
P.O. Box 1407
Lincolnshire, IL 60069-1407

You must send your first written appeal (Level I) to the Benefit Determination Review Team within 60 days of the statement date on Page 1 of the Level I Eligibility/Participation Appeal Form.

If you do not send the Level I appeal within the 60-day period, your appeal will not be reviewed and you will forfeit any right to any further review of your eligibility and/or participation issue.

If you timely file your appeal but it cannot be processed because, for example, you did not follow the correct procedures for filing an appeal, the Benefit Determination Review Team (the “Team”) will notify you in writing as soon as possible and tell you what steps you must take to have your request reviewed.

You will usually receive written notice of the Team’s decision within 30 days of the date the Team receives your appeal. You will be notified if special circumstances require more than 30 days. In no case will the review process take longer than 60 days from the date your Level I appeal was received by the Team. If you are requested to provide additional information to process your appeal, you will have 45 days to provide the additional information. (The actual due date is stated in the notice.) The days from the date you are sent the notice to the due date for the requested information (or, if earlier, the date you respond to the request) will not be counted as part of the time by which the Team must make a decision on your appeal. If you do not send the additional information by the due date, your appeal will be reviewed without the information.

If your appeal is denied, the written notice will explain the reasons for the denial and provide you with instructions on how to submit a Level II Eligibility/Participation Final Appeal if you are not satisfied with the Level I review.
Level II Eligibility/Participation Final Appeal
To file a second and final review of the eligibility and/or participation issue, send a letter to the Plan Administrator at:

Marriott International, Inc.
Benefits Department 52-935.62
10400 Fernwood Road
Bethesda, MD 20817

You must send your final written appeal (Level II) to the Plan Administrator within 60 days of the date listed in the Level I denial letter. Your final Level II appeal should include the following:

• Reasons for the appeal;
• Copies of any documents or records that support your position;
• Factors you believe were not considered in your first appeal; and
• Additional pertinent information that may have been received after you filed your first appeal.

The Plan Administrator will review your Level II appeal and make a final decision. You will usually receive written notice of this decision within 60 days of the date the Plan Administrator receives your appeal. You will be notified if special circumstances require more than 60 days. In no case will the review process take longer than 120 days from the date your Level II appeal was received by the Plan Administrator.

The Plan Administrator has full discretionary authority to interpret the provisions of the Plan with respect to eligibility and participation. All decisions of the Plan Administrator are final and binding on all parties.

NOTE: If you do not hear from the Plan Administrator within 60 days from the date you requested a review, contact the Plan Administrator to make sure your appeal was received.

DEPENDENT VERIFICATION ELIGIBILITY/PARTICIPATION APPEAL
If you believe that your request to participate in the Plan has been administered incorrectly, call the myHR Service Center at 1-888-884-4myHR (1-888-884-6947) to speak with a myHR Service Center Representative.

The myHR Service Center Representative will discuss your eligibility and/or participation issue with you and make a determination. If you disagree with the myHR Service Center Representative’s determination, you will be transferred to the myHR Service Center Manager for additional assistance. If you disagree with the Manager’s determination, you may appeal the eligibility and/or participation issues. The appeals process is described below.

Eligibility/Participation Appeal
To request a review of the myHR Service Center Manager’s determination, you must request an Eligibility/Participation Appeal Form from the Manager.

Upon request, the Manager will mail you an Eligibility/Participation Appeal Form within three business days. You must send the completed and signed Eligibility/Participation Appeal Form and copies of any documents or records that support your request to:

Benefit Determination Review Team
P.O. Box 1407
Lincolnshire, IL 60069-1407

You must send your written appeal to the Benefit Determination Review Team within 60 days of the statement date on Page 1 of the Eligibility/Participation Appeal Form.
If you do not send the appeal within the 60-day period, your appeal will not be reviewed and you will forfeit any right to any further review of your eligibility and/or participation issue.

If you timely file your appeal but it cannot be processed because, for example, you did not follow the correct procedures for filing an appeal, the Benefit Determination Review Team (the “Team”) will notify you in writing as soon as possible and tell you what steps you must take to have your request reviewed.

**BENEFIT CLAIMS APPEALS AND EXTERNAL REVIEW**

As a Health Plan participant, you have the right to file an appeal about coverage for service(s) you have received from your health care provider or Aetna if you are not satisfied with the outcome of the initial determination as stated in the Explanation of Benefits (EOB) sent to you and the appeal is regarding a change in the decision for the following:

- Certification of health care services;
- Claim payment;
- Plan interpretation;
- Benefit determination, including plan limitations or exclusions; and/or
- Eligibility for coverage, including retroactive termination of coverage (whether or not there is an adverse effect on any particular benefit).

**NOTE: DEEMED EXHAUSTION OF INTERNAL CLAIMS APPEAL PROCESS**

Generally, you are required to complete the Health Plan’s internal appeals process (both Levels I and II) before being able to obtain an External Review or bring an action in litigation. However, if Aetna does not strictly adhere to all claim determination and appeal procedures under applicable federal law, you are considered to have exhausted the Health Plan’s internal appeals process (“Deemed Exhaustion”) and may proceed with External Review or may pursue any available remedies under Section 502(a) of ERISA.

**INTERNAL CLAIMS APPEAL PROCESS**

**Level I Claims Appeal**

You may file a Level I claims appeal, in writing, to Aetna at:

National Accounts CRT  
P.O. Box 14463  
Lexington, KY 40512

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services at the number listed on your ID card. You or your authorized representative may appeal urgent care claim denials either verbally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and Aetna by telephone, facsimile, or other similar method.

You must make your written appeal to Aetna within 180 days following receipt of an adverse benefit decision. Failure to comply with this important deadline may cause you to forfeit any right to any further review of your claim under these procedures or in a court of law.

Your appeal should include the group name (that is, your employer), your name, your member ID number or other identifying information shown on the front of the Explanation of Benefits (EOB), and any other comments, documents, records, and other information you would like to have considered, whether or not submitted in connection with the initial claim. An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.
Notice of Decision on Level I Claims Appeal

You will receive a written notice from Aetna regarding your appeal as follows:

Urgent Care Claims
For an urgent care claim, you will be notified as soon as possible, taking into account the medical urgency, but no later than 36 hours after Aetna receives your appeal, regardless of whether the claim is approved or denied, in whole or in part. Because of the urgency of these claims, you may receive notice by phone, fax, or e-mail.

Pre-Service Claims and Post-Service Claims
For a pre-service claim, you will be notified within a reasonable time appropriate to the medical circumstances, but no later than 15 days after Aetna receives your appeal, regardless of whether the appeal is approved or denied, in whole or in part.

For a post-service claim, you will be notified within a reasonable time, but no later than 30 days after Aetna receives your appeal, regardless of whether the appeal is approved or denied, in whole or in part.

Concurrent Care Claims
For a claim to extend an ongoing course of treatment that is a claim involving urgent care, you will be notified as soon as possible, taking into account the medical urgency, but no later than 36 hours after Aetna receives your appeal.

Any other request to extend an ongoing course of treatment will be decided according to the applicable time limits for pre-service claims (no later than 15 days after Aetna receives your appeal) and post-service claims (no later than 30 days after Aetna receives your appeal).

Content of Decision on Level I Claims Appeal
If your Level I appeal is denied, in whole or in part, the written notice will explain (1) why the appeal was denied and refer to the specific Plan provisions on which the denial was based; (2) what additional information is needed in order to have your claim reconsidered at the next appeal level, if applicable, and why the information is needed; (3) if applicable, any internal rules, guidelines, protocols, or similar criteria that were relied upon in making the decision (or state that such rules, etc. were relied upon and how you can get a copy free of charge); (4) if applicable, the clinical or scientific judgment for the decision if it was based on a medical necessity, experimental treatment or similar exclusion or limit (or state that such explanation will be provided upon request); and (5) the Plan’s appeal procedures and time limits, including a statement that you have a right to bring a civil action under Section 502(a) of ERISA after you have made the mandatory appeals.

LEVEL II CLAIMS APPEAL
If you are dissatisfied with the Level I claims appeal decision, you may file a Level II claims appeal with Aetna by writing to:

National Accounts CRT
P.O. Box 14463
Lexington, KY 40512

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services at the number listed on your ID card. You or your authorized representative may appeal urgent care claim denials either verbally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and Aetna by telephone, facsimile, or other similar method.

You must make your written appeal to Aetna within 60 days of receipt of the Level I appeal decision. Failure to comply with this important deadline may cause you to forfeit any right to any further review of your claim under these procedures or in a court of law.
Your Level II appeal must include the following:

- The reasons for the second level appeal; and
- Any written comments, documents, records, or other information supporting your appeal.

If requested, you will be given reasonable access to, and copies of, all documents, records, or other information relevant to your claim, free of charge, and the identity of any medical or vocational expert consulted in connection with the Level I appeal (regardless of whether the expert’s advice was used to deny your claim).

Upon receipt of your Level II appeal, Aetna will make a full and fair review of your claim, taking into account all comments, documents, records, and other information submitted by you (regardless of whether the information was submitted or considered in the Level I appeal). The review will not defer to Aetna’s prior decision(s) and will not be conducted by the person or persons who made the prior decision(s) or his or her subordinate. If Aetna’s denial was based on medical judgment, Aetna will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with its prior decision(s) nor a subordinate of any such person. Before Aetna makes its final decision, if applicable, you will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any or additional rationale as soon as possible and in sufficient time to allow you the opportunity to respond before Aetna issues its Level II appeal decision.

**Notice of Decision on Level II Claims Appeal**

You will receive a written notice from Aetna regarding your Level II claims appeal as follows:

**Urgent Care Claims**

For an urgent care claim, you will be notified as soon as possible, taking into account the medical urgency, but no later than 36 hours after Aetna receives your appeal, regardless of whether the claim is approved or denied, in whole or in part. Because of the urgency of these claims, you may receive notice by phone, fax, or e-mail.

**Pre-Service Claims and Post-Service Claims**

For a pre-service claim (other than an urgent care claim), you will be notified within a reasonable time appropriate to the medical circumstances, but no later than 15 days after Aetna receives your Level II appeal, regardless of whether the appeal is approved or denied, in whole or in part.

For post-service claims, you will be notified within a reasonable time, but no later than 30 days after Aetna receives your Level II appeal, regardless of whether the appeal is approved or denied, in whole or in part.

**Concurrent Care Claims**

For a claim to extend an ongoing course of treatment that is not a claim involving urgent care, you will be notified according to the applicable time limits for pre-service claims (no later than 15 days after Aetna receives your Level II appeal) and post-service claims (no later than 30 days after Aetna receives your Level II appeal).

**Content of Decision on Level II Claims Appeals**

If your Level II claims appeal is denied, in whole or in part, the written notice will explain (1) why the appeal was denied and refer to the specific Plan provisions on which the denial was based; (2) that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim; (3) if applicable, any internal rules, guidelines, protocols, or similar criteria that were relied upon in making the decision (or state that such rules, etc. were relied upon and how you can get a copy free of charge); (4) if applicable, the clinical or scientific judgment for the decision if it was based on a medical necessity, experimental treatment, or similar exclusion or limit (or state that such explanation will be provided upon request); and (5) the Plan’s voluntary external review
procedures. The denial letter will also state that you have the right to either bring a civil action under Section 502(a) of ERISA after the Level II appeal or file a voluntary appeal for external review.

Exhaustion of Process
Other than in a case of Deemed Exhaustion, you must exhaust the applicable Level I and Level II appeals process before you establish any:

- Litigation,
- External Review,
- Arbitration, or
- Administrative proceeding,

regarding an alleged breach of the policy terms by Aetna Life Insurance Company, or any matter within the scope of the appeals procedure.

VOLUNTARY EXTERNAL REVIEW PROCESS

Request for Independent External Review
You may voluntarily file a request for External Review of any final internal appeal determination that qualifies.

Other than in a case of Deemed Exhaustion, you must complete Level I and Level II, as described above, before you can request External Review. Subject to verification procedures that Aetna may establish, your authorized representative may act on your behalf in requesting and pursuing External Review.

You may request External Review for any initial determination as stated in the Explanation of Benefits (EOB) sent to you or any final review that qualifies as set forth below. The written notice you receive regarding Aetna’s initial determination or its decision on your Level II appeal will describe the process to follow if you wish to request an External Review and will include a copy of the Request for External Review form.

You must submit the Request for External Review form to Aetna within 123 calendar days after you receive notice of Aetna’s initial determination as stated in the Explanation of Benefits (EOB) or decision on your Level II appeal. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. You also must include a copy of Aetna’s notice and all other pertinent information that supports your request for External Review.

If you request External Review, any applicable statute of limitations will be tolled while the External Review is pending. Requesting External Review will have no effect on your rights to any other benefits under the Plan. External Review is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to request External Review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

External Review Process
Aetna’s External Review process gives you the opportunity to have a review of Aetna’s initial determination as stated in the Explanation of Benefits (EOB) sent to you, including its decision on your Level II appeal, conducted pursuant to applicable federal law. Your request will be eligible for External Review if the following are satisfied:

- Aetna does not strictly adhere to all claim determination and appeal requirements under applicable federal law;
- Level I and Level II of the Health Plan’s internal appeals process have been exhausted; or
• The appeal relates to a rescission (i.e., cancellation or discontinuance of coverage which has a retroactive effect).

A denial of coverage based upon your eligibility for Plan participation is not eligible for External Review.

If upon the Level II appeal, Aetna upholds the coverage denial and it is determined that you are eligible for External Review, you will be informed, in writing, of the steps necessary to request External Review.

**Preliminary Review**

Within five (5) business days after Aetna receives your Request for External Review, it will conduct a preliminary review to determine the following: you were covered under the Health Plan at the time the service was requested or provided, the determination does not relate to eligibility for Plan participation, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review.

Within one business day after completion of the preliminary review, Aetna will issue you a written notice of its determination. If the Request for External Review is complete but not eligible for External Review, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-EBSA [1-866-444-3272]). If the Request for External Review is not complete, the notice will describe the information or materials needed to make the request complete and you will have until the later of the 123 calendar days filing period, or the 48-hour period after you receive the notice, to submit the information or materials.

**Referral to Independent Review Organization (IRO)**

An Independent Review Organization (IRO) refers the case for review by a neutral, independent physician with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna, and the Plan.

If Aetna determines that the Request for External Review is eligible for External Review, Aetna will assign an IRO accredited as required under federal law, to conduct the External Review. The assigned IRO will timely notify you in writing of the request’s eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within ten (10) business days following the date of receipt, additional information that the IRO must consider when conducting the External Review. Within five (5) business days after its assignment to the IRO, Aetna will provide the IRO with all documents and information that Aetna considered in making its initial determination or decision on your Level II appeal. If Aetna fails to provide the documents within the five-day period, the IRO may unilaterally terminate External Review and make a decision to reverse Aetna’s coverage decision. If the IRO makes the decision to terminate External Review, the IRO will, within one (1) business day of making its decision, notify you, Aetna, and the Plan.

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

• Your medical records;
• The attending health care professional's recommendation;
• Reports from appropriate health care professionals and other documents submitted by the Health Plan, you, or your treating provider;
• The terms of your Health Plan to ensure that the IRO's decision is not contrary to the terms of the Health Plan, unless the terms are inconsistent with applicable law;
• Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

• Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Health Plan or with applicable law; and

• The opinion of the IRO’s clinical reviewer or reviewers after considering the information described above to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO will provide written notice of its Final External Review Decision within 45 days after receiving the Request for External Review. The IRO will deliver its Final External Review Decision to you, Aetna and the Plan.

The IRO’s notice will contain: (1) a general description of the reason for the Request for External Review, including information sufficient to identify the claim (e.g., the date or dates of service, the health care provider, the claim amount [if available], the diagnosis code and its meaning, the treatment code and its meaning, and the reasons for the previous denials); (2) the date the IRO received the External Review assignment from Aetna and the date of the IRO’s decision; (3) references to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination; (4) a discussion of the principal reason(s) for the IRO’s decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision; (5) a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or you; (6) a statement that you may still be eligible to seek judicial review of any adverse external review determination; and (7) current contact information, including the phone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist you.

If the IRO’s Final External Review Decision reverses Aetna’s initial determination as stated in the Explanation of Benefits (EOB) sent to you or Level II appeal decision, the Health Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

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

**Expedit**ed **External Review Process**

You may request an expedited External Review upon receiving:

• An initial determination as stated in an Explanation of Benefits (EOB) involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

• A Level II appeal decision, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Level II appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

**Preliminary Review**

Immediately upon receipt of the request for expedited External Review, Aetna will conduct the Preliminary Review described above for standard External Review. Aetna will immediately send you a notice of its determination.
Referral to Independent Review Organization (IRO) for Expedited Review

If Aetna determines that the Request for Expedited External Review is eligible for expedited External Review, Aetna will assign an IRO. Aetna will provide or transmit all necessary documents and information considered in making its initial determination or its Level II decision to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method. The IRO will review the information and documents described above for standard External Review and will provide a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an Expedited External Review. If the notice is not in writing, within 48 hours after the date of providing the notice, the IRO will provide written confirmation of the decision to you, Aetna, and the Plan. If the IRO’s decision reverses Aetna’s initial determination as stated in the Explanation of Benefits (EOB) sent to you or Level II appeal decision, Aetna immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

After its decision, the IRO will maintain records of all claims and notices associated with the expedited External Review process for six years. An IRO will make such records available for examination by you, the Plan, or the state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

CLAIM FIDUCIARY

For the purpose of Section 503 of Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, Aetna is a fiduciary with complete authority to review all denied claims for benefits under the Health Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its fiduciary responsibility, Aetna has discretionary authority to:

• Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and

• Construe any disputed or doubtful terms of the Health Plan.

Aetna has the right to adopt reasonable policies, procedures, rules, and interpretations of the Health Plan to promote orderly and efficient administration. Aetna may not act arbitrarily and capriciously, which would be an abuse of its discretionary authority.

The Company is responsible for making reports and disclosures required by ERISA, including the creation, distribution, and final content of:

• Summary Plan Descriptions (SPD);

• Summaries of Material Modifications (SMM); and

• Summary Annual Reports (SAR).

IMPORTANT PLAN DEFINITIONS

ACCIDENT

A sudden, unexpected, and unforeseen identifiable occurrence or event producing, at the time, objective symptoms of a bodily injury. The accident must occur while the person is covered under the Health Plan. The occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an illness or disease of any kind.

AFTER-TAX CONTRIBUTIONS
Contributions you make for your coverage after Social Security, federal, and state taxes have been deducted from your paycheck.

**AMBULANCE**
A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

**ANNUAL ENROLLMENT**
A period of time each fall when you can enroll for benefits or change your benefit selections. The enrollment and changes take effect on the first day of the next Plan Year, provided all Plan requirements have been met.

**BEFORE-TAX CONTRIBUTIONS**
Contributions you make for your coverage before Social Security, federal, and most state taxes are deducted from your paycheck.

**BEHAVIORAL HEALTH PROVIDER/PRACTITIONER**
A licensed organization or professional providing diagnostic, therapeutic, or psychological services for behavioral health conditions.

**BIRTHING CENTER**
A freestanding facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped, and run to provide prenatal care, delivery, and immediate postpartum care.
- Charges for its services.
- Is directed by at least one physician who is a specialist in obstetrics and gynecology.
- Has a physician or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital.
- Has at least two beds or two birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery, and the immediate postpartum period, full-time skilled nursing services directed by an R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle emergency medical conditions and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
• Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or
direct the facility.

• Keeps a medical record on each patient and child.

**BODY MASS INDEX**
This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the
weight in kilograms by the height in meters squared.

**BRAND-NAME PRESCRIPTION DRUG**
A prescription drug with a proprietary name assigned to it by the manufacturer or distributor and so
indicated by Medi-Span or any other similar publication designated by CVS/caremark.

**COBRA CONTINUATION COVERAGE**
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, which is a federal
law that requires most employers sponsoring group health plans to offer employees and their families the
opportunity to temporarily extend their health care coverage (COBRA continuation coverage) at group
rates in certain instances when coverage under the plan would otherwise end.

**COINSURANCE**
Both the percentage of covered expenses that the Health Plan pays and the percentage of covered expenses
that you pay. The percentage that the Health Plan pays varies by the type of expense. Refer to the *Benefits
at a Glance* section for specific information on coinsurance amounts. Coinsurance is also referred to as
"payment percentage."

**COPAY OR COPAYMENT**
The specific dollar amount or percentage required to be paid by you or on your behalf. The Health Plan
includes various copayments, and these copayment amounts or percentages are specified in the *Benefits
at a Glance* section.

**COSMETIC**
Services or supplies that alter, improve, or enhance appearance.

**COVERED EXPENSES**
Medical, dental, vision, or hearing services and supplies shown as covered under the Health Plan.

**CREDITABLE COVERAGE**
A person’s prior medical coverage as defined in the Health Insurance Portability and Accountability Act of
1996 (HIPAA).

Such coverage includes:
• Health coverage issued on a group or individual basis;
• Medicare;
• Medicaid;
• Health care for members of the uniformed services;
• A program of the Indian Health Service;
• A state health benefits risk pool;
• The Federal Employees’ Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a state, the government of the United States, or any subdivision of a state or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children’s Health Insurance Program (S-CHIP).

CUSTODIAL CARE
Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators, or catheters. Examples of custodial care include:
- Routine patient care, such as changing dressings, periodic turning, positioning in bed, and administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care, and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

DAY CARE TREATMENT
A partial confinement treatment program to provide treatment for you during the day. The hospital, psychiatric hospital, or residential treatment facility does not make a room charge for day care treatment. Such treatment must be available for at least four hours, but not more than 12 hours in any 24-hour period.

DEDUCTIBLE
The part of your covered expenses you pay before the Health Plan starts to pay benefits. Additional information regarding deductibles and deductible amounts can be found in the Benefits at a Glance section.

DEEMED EXHAUSTION
Failure of the Plan to strictly adhere to all the internal claims and appeals requirements, both as currently existing under ERISA and as modified under the Appeal and Review Mandate.

DENTIST
A legally qualified dentist or a physician licensed to do the dental work he or she performs.

DETOXIFICATION
The process by which an alcohol-intoxicated or drug-intoxicated, or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:
- Intoxicating alcohol or drug;
• Alcohol or drug-dependent factors; or
• Alcohol in combination with drugs;
as determined by a physician. The process must keep the physiological risk to the patient at a minimum and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

DURABLE MEDICAL AND SURGICAL EQUIPMENT (DME)
Equipment and the accessories needed to operate it, that are:
• Made to withstand prolonged use;
• Made for and mainly used in the treatment of a illness or injury;
• Suited for use in the home;
• Not normally of use to people who do not have a illness or injury;
• Not for use in altering air quality or temperature; and
• Not for exercise or training.

NOTE: Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids, and telephone alert systems.

E-VISIT
An online internet consultation between a network physician and an established patient about a non-emergency health care matter. This visit must be conducted through the Health Plan’s authorized internet E-visit service vendor.

EMERGENCY CARE
The treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition.

EMERGENCY MEDICAL CONDITION
A recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:
• Placing your health in serious jeopardy;
• Serious impairment to bodily function;
• Serious dysfunction of a body part or organ; or
• In the case of a pregnant woman, serious jeopardy to the health of the fetus.

ERISA
The Employee Retirement Income Security Act of 1974 (ERISA), as amended, which outlines certain basic rights and protections for all employees.

EXPERIMENTAL OR INVESTIGATIONAL
A drug, device, a procedure, or treatment determined to be experimental or investigational if:
• There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved;
• Approval required by the FDA has not been granted for marketing;
• A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes;
• It is a type of drug, device, or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
• The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational or for research purposes.

FAMILY AND MEDICAL LEAVE ACT (FMLA)
The Family and Medical Leave Act (FMLA), as amended, which requires employers with more than 50 employees to provide eligible workers with up to 12 weeks of unpaid leave each year for births, adoptions, foster care placements, and illnesses.

GENERIC PRESCRIPTION DRUG
A prescription drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by CVS/caremark.

HEALTH PLAN
Open Access Aetna Select, administered by the Aetna Life Insurance Company. The prescription drug program is administered by CVS/caremark.

HOMEBOUND
You are confined to your place of residence:
• Due to an illness or injury which makes leaving the home medically contraindicated; or
• Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered homebound include, but are not limited to, the following:
• You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
• You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

HOME HEALTH CARE AGENCY
An agency that meets all of the following requirements:
• Mainly provides skilled nursing and other therapeutic services;
• Is associated with a professional group (of at least one physician and one R.N.) which makes policy;
• Has full-time supervision by a physician or an R.N.;
• Keeps complete medical records on each person;
• Has an administrator; and
• Meets licensing standards.

**HOME HEALTH CARE**
Provides for continued care and treatment of an illness or injury. The care and treatment must be:

• Prescribed in writing by the attending physician; and
• An alternative to a hospital or skilled nursing facility stay.

**HOSPICE CARE**
Care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

**HOSPICE CARE AGENCY**
An agency or organization that meets all of the following requirements:

• Has hospice care available 24 hours a day.
• Meets any licensing or certification standards established by the jurisdiction where it is located.
• Provides:
  — Skilled nursing services;
  — Medical social services; and
  — Psychological and dietary counseling.
• Provides, or arranges for, other services which include:
  — Physician services;
  — Physical and occupational therapy;
  — Part-time home health aide services which mainly consist of caring for terminally ill people; and
  — Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
• Has at least the following personnel:
  — One physician;
  — One R.N.; and
  — One licensed or certified social worker employed by the agency.
• Establishes policies about how hospice care is provided.
• Assesses the patient's medical and social needs.
• Develops a hospice care program to meet those needs.
• Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency.
• Permits all area medical personnel to use its services for their patients.
• Keeps a medical record on each patient.
• Uses volunteers trained in providing services for non-medical needs.
• Has a full-time administrator.
HOSPICE CARE PROGRAM
A written plan of hospice care, which:

- Is established by and reviewed from time to time by a physician attending the person and appropriate personnel of a hospice care agency;
- Is designed to provide palliative and supportive care to terminally ill persons and supportive care to their families; and
- Includes an assessment of the person's medical and social needs and a description of the care to be given to meet those needs.

HOSPICE FACILITY
A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient hospice care to terminally ill persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians. At least one staff physician must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an R.N.
- Has a full-time administrator.

HOSPITAL
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of physicians;
- Provides 24-hour-a-day R.N. service;
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

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

HOSPITALIZATION
Is necessary and continuous confinement as an inpatient in a hospital is required and a charge for room and board is made.
ILLNESS
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

INFERTILE OR INFERTILITY
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- For a woman who is under 35 years of age, one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- For a woman who is 35 years of age or older, six months or more of timed, unprotected coitus, or six cycles of artificial insemination.

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

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

INSTITUTE OF EXCELLENCE (IOE)
A hospital or other facility that has contracted with Aetna to furnish services or supplies to an IOE patient in connection with specific transplants at a negotiated charge. A facility is an IOE facility only for those types of transplants for which it has signed a contract.

INSTITUTE OF QUALITY (IOQ)
A national network of health care facilities that are designated based on measures of clinical performance, access, and efficiency for bariatric surgery. Bariatric surgery, also known as weight loss surgery, refers to various surgical procedures to treat people living with morbid, or extreme, obesity.

LATE ENROLLEE
An employee in an eligible class who requests enrollment under the Health Plan after the initial enrollment period. In addition, this is an eligible dependent for whom the employee did not elect coverage within the initial enrollment period, but for whom coverage is elected at a later time.

However, an eligible employee or dependent may not be considered a late enrollee under certain circumstances. See the Enrollment section.

LIFETIME MAXIMUM
The most the Health Plan will pay for covered expenses incurred by any one covered person during his or her lifetime.

L.P.N.
A licensed practical or vocational nurse.

MAIL ORDER PHARMACY
An establishment in which prescription drugs are legally dispensed by mail or other carrier.

MAINTENANCE CARE
Care made up of services and supplies that:
• Are furnished mainly to maintain, rather than to improve, a level of physical or mental function; and
• Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

MAINTENANCE MEDICATION
Medications that you take on a regular basis, such as those for high blood pressure, diabetes, or birth control.

MEDICALLY NECESSARY OR MEDICAL NECESSITY
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 provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that provision of the service, supply or prescription drug is:

• In accordance with generally accepted standards of medical or dental practice;
• Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease;
• Not primarily for the convenience of the patient, physician, other health care or dental provider; and
• Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

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

To determine if a service, supply, or prescription is medical necessary, please call Member Services at 1-877-706-8776.

MENTAL DISORDER
An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist, or a psychiatric social worker. Any one of the following conditions is a mental disorder under the Health Plan:

• Anorexia / Bulimia Nervosa;
• Bipolar disorder;
• Major depressive disorder;
• Obsessive compulsive disorder;
• Panic disorder;
• Pervasive Mental Developmental Disorder (Autism);
• Psychotic disorders / Delusional Disorder;
• Schizo-affective disorder; or
• Schizophrenia.

MORBID OBESITY
A body mass index that is greater than 40 kilograms per meter squared, or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

**NEGOTIATED CHARGE**
The maximum charge a network provider has agreed to make for any service or supply for the purpose of the benefits under the Health Plan. The negotiated charge does not include or reflect any amount Aetna or an affiliate may receive under a rebate arrangement between Aetna or an affiliate and a drug manufacturer for any prescription drug, including prescription drugs on the preferred drug list.

**NETWORK PROVIDER**
A health care provider or pharmacy that has contracted to furnish services or supplies for a negotiated charge, but only if the provider is, with the Health Plan's consent, included in the directory as a network provider for:

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

**NETWORK SERVICE(S) OR SUPPLY(IES)**
A health care service or supply that is:

- Furnished by a network provider; or
- Furnished or arranged by your PCP.

**NIGHT CARE TREATMENT**
A partial confinement treatment program provided when you need to be confined during the night. A room charge is made by the hospital, psychiatric hospital, or residential treatment facility. Such treatment must be available at least:

- Eight hours in a row a night; and
- Five nights a week.

**NON-DUPLICATION OF BENEFITS**
A type of coordination of benefits under which the benefits payable by your secondary coverage plan are limited to the difference, if any, between the amount paid by the primary plan and the amount that would have been payable by the secondary plan had that plan been primary.

**NON-OCCUPATIONAL ILLNESS**
A non-occupational illness is an illness that does not:

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

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

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

**NON-OCCUPATIONAL INJURY**
A non-occupational injury is an accidental bodily injury that does not:
• Arise out of (or in the course of) any work for pay or profit; or
• Result in any way from an injury which does.

**NON-PREFERRED DRUG (NON-FORMULARY)**
A prescription drug that is not listed on the preferred drug list.

**NON-SPECIALIST**
A physician who is not a specialist.

**OCCUPATIONAL INJURY OR OCCUPATIONAL ILLNESS**
An injury or illness that:

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

**OCCURRENCE**
A period of disease or injury. An occurrence ends when 60 consecutive days have passed during which the covered person:

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

**ORTHODONTIC TREATMENT**
Any:

• Medical service or supply; or
• Dental service or supply;
furnished to prevent or to diagnose or to correct a misalignment:

  — Of the teeth;
  — Of the bite; or
  — Of the jaws or jaw joint relationship;
whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

• The installation of a space maintainer; or
• A surgical procedure to correct malocclusion.

**OUT-OF-NETWORK PROVIDER**
A health care provider or pharmacy that has not contracted with Aetna to furnish services or supplies at a negotiated charge.

**OUT-OF-POCKET LIMIT**
The maximum annual out-of-pocket amount you are responsible to pay for your medical copayments, coinsurance, deductibles, and other eligible out-of-pocket expenses for covered expenses during the
calendar year. Once you satisfy the out-of-pocket limit, the Health Plan will pay 100% of most covered expenses that apply toward the limit for the rest of the calendar year. The out-of-pocket limit applies to both network and out-of-network benefits.

**PARTIAL CONFINEMENT TREATMENT**
A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat substance abuse or mental disorders. The plan must meet these tests:

- It is carried out in a hospital, psychiatric hospital, or residential treatment facility on less than a full-time inpatient basis;
- It is in accordance with accepted medical practice for the condition of the person;
- It does not require full-time confinement; and
- It is supervised by a psychiatric physician who weekly reviews and evaluates its effect.

Day care treatment and night care treatment are considered partial confinement treatment.

**PARTICIPANT**
An employee or dependent, , and same-sex partner and domestic partner or their children, eligible to participate in the Health Plan; whose election to participate in the Health Plan has become and remains effective; whose contributions are paid up to date, where applicable; and whose participation has not been cancelled for non-payment of contributions or for any other reason.

**PHARMACY**
An establishment in which prescription drugs are legally dispensed. “Pharmacy” includes a retail pharmacy, mail order pharmacy, and specialty pharmacy.

**PHYSICIAN**
A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

**PLAN**
The Marriott International, Inc. Medical Plan

**PLAN YEAR**
The calendar year (January 1 through December 31).

**PRECERTIFICATION OR PRECERTIFY**
A process in which the Health Plan is contacted before certain services are provided, such as hospitalization or outpatient surgery, or prescription drugs are prescribed to determine whether the services being recommended or the drugs prescribed are considered covered expenses under the Health Plan. It is not a guarantee that benefits will be payable.

**PREFERRED DRUG LIST**
A listing of prescription drugs established by CVS/caremark, which includes both brand-name prescription drugs and generic prescription drugs. This list is subject to periodic review and modification by CVS/caremark. A copy of the preferred drug list will be available upon your request or may be accessed on the CVS/caremark Web site at [www.caremark.com](http://www.caremark.com).

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

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

**PRESCRIPTION DRUG**
A drug, biological, or compounded prescription which, by state and federal law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid health care professional. Covered injectable drugs include injectable insulin.

**PRIMARY CARE PHYSICIAN (PCP)**
A network provider who:
- Is selected by a person from the list of primary care physicians in the directory;
- Supervises, coordinates, and provides initial care and basic medical services to a person as a general or family care practitioner or, in some cases, as an internist or a pediatrician; and
- Is shown on the Health Plan’s records as the person’s PCP.

**PSYCHIATRIC HOSPITAL**
An institution that meets all of the following requirements.
- Mainly provides a program for the diagnosis, evaluation, and treatment of substance abuse or mental disorders.
- Is not mainly a school or a custodial, recreational, or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatric physician who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
• Provides, at all times, psychiatric social work and nursing services.
• Provides, at all times, skilled nursing services by licensed nurses who are supervised by a full-time R.N.
• Prepares and maintains a written plan of treatment for each patient based on medical, psychological, and social needs. The plan must be supervised by a psychiatric physician.
• Makes charges.
• Meets licensing standards.

**PSYCHIATRIC PHYSICIAN**
A physician who:
• Specializes in psychiatry; or
• Has the training or experience to do the required evaluation and treatment of substance abuse or mental disorders.

**QUALIFIED BENEFICIARY(IES)**
Any person who was a covered dependent under the Health Plan on the date before the initial qualifying event. In addition, a child who is born to, placed for adoption with, or adopted by an employee receiving COBRA continuation coverage and added to that coverage is a qualified beneficiary. For purposes of COBRA continuation coverage, the Health Plan treats domestic partners) and their children covered by the Health Plan as qualified beneficiaries.

Qualified beneficiaries are entitled to COBRA continuation coverage rights separately from the covered employee and can maintain continued coverage even if the covered employee cancels coverage.

**QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**
A judgment, decree, or order issued by a court or through an administrative process, which has the force and effect of state law providing for child support or health benefit coverage and which satisfies applicable federal requirements.

**RECOGNIZED CHARGE**
Only that part of a charge which is less than or equal to the recognized charge amount is a covered benefit. “Recognized charge” is also referred to as “reasonable and customary” charge. The recognized charge amount for a service or supply is the lowest of:

• The provider's usual charge for furnishing it; and
• The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed, or coded; or
  —For non-facility charges, Aetna uses the provider charge data from the Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months.
  —For facility charges, Aetna uses the charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished.

In determining the recognized charge amount for a service or supply that is:

• Unusual;
• Not often provided in the geographic area; or
• Provided by only a small number of providers in the geographic area.
Aetna may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The recognized charge amount in other geographic areas.

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

**NOTE:** As used above, the term “geographic area” means a Prevailing HealthCare Charges System (PHCS) expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service zip codes.

If the volume of charges in a single three-digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three-digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three-digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three-digit zip codes, PHCS never crosses state lines.

This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association and the Centers for Medicare and Medicaid Services are utilized.

**REHABILITATION FACILITY**
A facility, or a distinct part of a facility, which provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

**REHABILITATIVE SERVICES**
The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining if you are disabled by illness or injury.

**RESIDENTIAL TREATMENT FACILITY (SUBSTANCE ABUSE)**
An institution that meets all of the following requirements:

- On-site licensed behavioral health provider 24 hours a day, seven days a week;
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission);
- Is admitted by a physician;
- Has access to necessary medical services 24 hours a day, seven days a week;
- If the participant requires detoxification services, must have the availability of on-site medical treatment 24 hours a day, seven days a week, which must be actively supervised by an attending physician;
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs;
- Offers group therapy sessions with at least an R.N. or Masters-Level Health Professional;
- Has the ability to involve family/support systems in therapy (required for children and adolescents, encouraged for adults);
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy;
- Has peer-oriented activities;
- Services are managed by a licensed behavioral health provider who, while not needing to be individually contracted, needs to (1) meet Aetna’s credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director);
- Has an individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;
- Provides a level of skilled intervention consistent with patient risk;
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located;
- Is not a Wilderness Treatment Program or any such related or similar program, school, and/or education service;
- Has the ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally;
- Has 24-hours a day, seven days a week supervision by a physician with evidence of close and frequent observation; and
- Has on-site, a licensed behavioral health provider, medical, or substance abuse professionals 24 hours a day, seven days a week.

**RESIDENTIAL TREATMENT FACILITY (MENTAL DISORDERS)**

An institution that meets all of the following requirements:

- On-site licensed behavioral health provider 24 hours per day, seven days a week;
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission);
- Is admitted by a physician;
- Has access to necessary medical services 24 hours per day, seven days a week;
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs;
- Offers group therapy sessions with at least an R.N. or Masters-Level Health professional;
- Has the ability to involve family/support systems in therapy (required for children and adolescents, encouraged for adults);
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy;
- Has peer-oriented activities;
- Services are managed by a licensed behavioral health provider who, while not needing to be individually contracted, needs to (1) meet Aetna’s credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director);
- Has an individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;
- Provides a level of skilled intervention consistent with patient risk;
• Meets any and all applicable licensing standards established by the jurisdiction in which it is located; and
• Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

R.N.
A registered nurse.

ROOM AND BOARD
Charges made by an institution for room and board and other medically necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

SELF-FUNDED
A plan under which the employer pays the cost of all medical claims from the general assets of the employer and employee contributions, rather than through the purchase of insurance contracts. Typically, however, administrative services are contracted to a company specializing in administering benefits. The Plan is self-funded.

SELF-INJECTABLE DRUG(S)
Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

SEMI-PRIVATE ROOM RATE
The room and board charge that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, the Health Plan will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

SERVICE AREA
The geographic area, as determined by Aetna, in which network providers for the Health Plan are located.

SKILLED NURSING FACILITY
An institution that meets all of the following requirements:

• Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  — Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N., and
  — Physical restoration services to help patients to meet a goal of self-care in daily living activities;
• Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time R.N.;
• Is supervised full-time by a physician or an R.N.;
• Keeps a complete medical record on each patient;
• Has a utilization review of the plan;
• Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders;
• Charges patients for its services;
• Is an institution or a distinct part of an institution that meets all of the following requirements:
  — It is licensed or approved under state or local law, and
It is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

- Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations,
  - The Bureau of Hospitals of the American Osteopathic Association, or
  - The Commission on the Accreditation of Rehabilitative Facilities.

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g. acute) and portions of a hospital designated for skilled or rehabilitation services.

“Skilled nursing facility” does not include:

- Institutions which provide only:
  - Minimal care,
  - Custodial care services,
  - Ambulatory, or
  - Part-time care services; or

- Institutions which primarily provide for the care and treatment of substance abuse or mental disorders.

**SKILLED NURSING SERVICES**

Services that meet all of the following requirements:

- The services require medical or paramedical training;
- The services are rendered by an R.N. or L.P.N. within the scope of his or her license; and
- The services are not custodial.

**SPECIALIST**

A physician who practices in any generally accepted medical or surgical sub-specialty.

**SPECIALTY PHARMACY NETWORK**

A network of pharmacies designated to fill specialty medications. These are high-cost medications that treat complex conditions and generally require specialized delivery. Specialty medications include most injectables—those administered in a doctor’s office, as well as those administered at home.

**STAY**

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

**SUBSTANCE ABUSE**

A physical or psychological dependency, or both, on a controlled substance or alcohol agent. (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food, or caffeine intoxication.

**SURGERY CENTER**
A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped, and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital; and
  - Dentists who perform oral surgery.
- Has at least two operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic X-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions.

The surgery center must have all of the following:

- A physician trained in cardiopulmonary resuscitation;
- A defibrillator;
- A tracheotomy set;
- A blood volume expander;
- A written agreement with a hospital in the area for immediate emergency transfer of patients;
- Written procedures for such a transfer that are displayed and the staff must be aware of them;
- Physicians who do not own or direct the facility; and
- A medical record on each patient.

**TERMINALLY ILL (HOSPICE CARE)**
A medical prognosis of six months or less to live.

**URGENT ADMISSION**
A hospital admission by a physician due to:

- The onset of or change in a illness;
- The diagnosis of a illness; or
- An injury.

The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for the confinement becomes apparent.

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

**URGENT CONDITION**
A sudden illness, injury, or condition that:
• Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
• Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
• Does not require the level of care provided in the emergency room of a hospital; and
• Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

**WALK-IN CLINIC**
Network, free-standing health care facilities. They are alternatives to physician’s office visits for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. They are not alternatives for emergency room services or the ongoing care provided by a physician. Neither an emergency room nor the outpatient department of a hospital will be considered a walk-in clinic.

**WEEK-ENDING DATE**
The end of the payroll cycle, which is designated as the Friday of each week.
IMPORTANT ADDRESSES AND PHONE NUMBERS

PLAN ADMINISTRATOR
Marriott International, Inc.
Benefits Department 52-935.62
10400 Fernwood Road
Bethesda, MD 20817
1-301-380-4169

AETNA
Aetna Life Insurance Company
151 Farmington Ave.
Hartford, CT 06156
1-877-706-8776
COBRA CONTINUATION COVERAGE

This section describes COBRA continuation coverage for medical, dental, and vision. (For information on COBRA continuation coverage for the Health Care Spending Account, see the Spending Accounts Summary Plan Description.)

WHAT COBRA CONTINUATION COVERAGE IS
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, is a federal law that requires most employers sponsoring group health plans to offer employees and their families the opportunity to temporarily extend their group health care coverage (COBRA continuation coverage) at group rates in certain instances when coverage under the Plan would otherwise end.

OTHER COVERAGE OPTIONS
There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers our monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA continuation coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

ELIGIBILITY FOR COBRA CONTINUATION COVERAGE
You and/or your dependents (qualified beneficiaries) who were active participants in a group health plan on the day before active coverage was lost (due to one of the qualifying events listed in the following chart) are eligible for COBRA continuation coverage.

IF YOU CHOOSE COBRA CONTINUATION COVERAGE
If you timely choose COBRA continuation coverage, the Company will provide you with the same coverage provided to active employees and their family members. This means that if the coverage for active employees and their family members is modified, your coverage will also be modified. You may continue the same coverage you had at the time COBRA continuation coverage rights began, but you may not add coverage or switch to another group health plan until the next annual enrollment period, unless you experience a qualifying event. Refer to “Qualified Life Events” in the Enrollment section for a discussion of qualifying events.

COBRA CONTINUATION COVERAGE ADMINISTRATION
COBRA continuation coverage is administered by Aon Hewitt Associates on behalf of the Company. You may call the myHR Service Center with any questions regarding this coverage.
INITIAL QUALIFYING EVENTS AND LENGTH OF COBRA CONTINUATION COVERAGE

<table>
<thead>
<tr>
<th>When Coverage Is Lost Because...</th>
<th>COBRA Continuation Coverage Is Offered to...</th>
<th>For...</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Your employment ends voluntarily or involuntarily (for reasons other than gross misconduct); or You become ineligible for coverage or your cost for coverage increases due to a reduction in your hours of employment to part-time, temporary, or pool status.</td>
<td>You and your covered dependents</td>
<td>Up to 18 months*</td>
</tr>
<tr>
<td>• You die; or Your covered spouse legally separate or divorce (whichever occurs earlier).**</td>
<td>Your covered dependents</td>
<td>Up to 36 months</td>
</tr>
<tr>
<td>• Your dependent child becomes ineligible for coverage due to age.**</td>
<td>Your covered child</td>
<td>Up to 36 months</td>
</tr>
<tr>
<td>• You and your domestic partner dissolve the partnership with an affidavit.**</td>
<td>Your covered domestic partner and his or her covered dependent children</td>
<td>Up to 36 months</td>
</tr>
</tbody>
</table>

*Regardless of the participant’s age at the time your employment ends or you become ineligible for coverage, participants will be offered COBRA continuation coverage for up to 18 months. The coverage may increase to 29 months if you or a covered dependent is disabled before or within 60 days after the date of the qualifying event. (See “Special Rules for Disabled Qualified Beneficiaries” later in this section.) The coverage may also increase for your covered dependents if you were entitled to Medicare before losing coverage. (See “Medicare Extension for Dependents” later in this section.) You must notify the myHR Service Center that you are entitled for Medicare in order for the extension to be offered to your dependents.

**You or a qualified beneficiary(ies) must notify the myHR Service Center of the qualifying event within 60 days by using the myHR Web site or by calling the myHR Service Center; otherwise, your dependents will not be eligible for COBRA continuation coverage. (See “How to Apply for COBRA Continuation Coverage” later in this section.)

COVERED FOR YOUR DEPENDENTS IF YOU DIE
If you die while you are covered under the Plan, COBRA continuation coverage will be automatically provided to your covered dependents for the first two months at no cost. After the first two months, your covered dependents may elect to continue the coverage for up to the remaining 34 months and pay the required premium payments for COBRA continuation coverage. (See “Cost of COBRA Continuation Coverage” later in this section.)

HOW TO APPLY FOR COBRA CONTINUATION COVERAGE
The Plan Administrator will automatically send a COBRA continuation coverage notice, which includes enrollment information, if you and your covered dependents lose coverage under the Plan because of:
• Termination of your employment (for reasons other than gross misconduct);
• Change in your employment status;
• Reduction in your hours of employment; or
• Your death.

You must enroll within 60 days from the date of the COBRA Enrollment Notice (or by the date specified in the notice, if later) to be covered. You must also enroll your covered spouse, domestic partner, and/or dependent children in the Plan during the 60-day period if you want to cover them.

Each qualified beneficiary has a separate right to enroll in COBRA continuation coverage. This means that your covered spouse and/or dependent children may enroll in COBRA continuation coverage even if you choose not to enroll.

You may enroll by using the myHR Web site or by calling the myHR Service Center. If COBRA continuation coverage is not elected within the time allowed, coverage ends on the date stated in the COBRA continuation coverage notice. To continue COBRA continuation coverage, you must pay the full amount of the monthly premiums specified in the notice by the due date.

If you enroll online, you can print a Confirmation of Enrollment, which is a copy of your benefit elections, for your records. If you enroll through a myHR Service Center Representative, a printed Confirmation of Enrollment will be mailed to your home approximately one week after you enroll. If you enroll by calling a representative and do not receive a Confirmation of Enrollment, call the myHR Service Center.

Review your Confirmation of Enrollment carefully to make sure that your benefit selections are correct. If you see a problem and do not call the myHR Service Center to correct the problem within 14 days of the Confirmation of Enrollment date, you may not be able to change your coverage until the next annual enrollment period, unless you experience a qualified life event.

You or a qualified beneficiary must notify the myHR Service Center within 60 days after your divorce or legal separation, the dissolution of your domestic partnership, or your child’s loss of coverage in order to receive a COBRA continuation coverage notice and enrollment information for coverage for your formerly eligible dependents. Notification must be made by using the myHR Web site or by calling the myHR Service Center. If the myHR Service Center is not notified within the 60-day period, the dependent’s coverage cannot be continued under COBRA.

If you elect COBRA continuation coverage and it is rejected, the myHR Service Center will notify you of the reason within 14 days after it receives your enrollment request.

**HOW TO ADD A DEPENDENT TO COBRA CONTINUATION COVERAGE**

You may add eligible dependents to your coverage during the annual enrollment period by using the myHR Web site or by calling the myHR Service Center. You may also add a newly eligible dependent (for example, a newborn child or a spouse) to your COBRA continuation coverage during the plan year by using the myHR Web site or by calling the myHR Service Center—generally within 31 days of the event. Coverage will take effect retroactively to the date of your qualified event.

In the following exceptions, you must notify the myHR Service Center within 60 days of the event:
• Birth;
• Adoption or placement for adoption; or
• Loss of dependent status (for example, divorce or a child reaching age 26).

You must notify the myHR Service Center of any changes to your (or your dependent’s) address.

**NOTE:** A child born to, placed for adoption with, or adopted by an employee receiving COBRA continuation coverage and added to that coverage is a qualified beneficiary. Qualified beneficiaries are
entitled to COBRA continuation coverage rights separately from the covered employee and can maintain continued coverage even if the employee cancels coverage.

COST OF COBRA CONTINUATION COVERAGE
Each participant who continues coverage under COBRA must pay the full cost of coverage, plus 2% for administrative expenses. COBRA continuation coverage is paid in monthly premiums, which are due on the first day of each month.

Once you are enrolled, payment notices will be mailed to you for monthly premium payments. Payment is due on the first day of the month for which coverage is to be provided.

Your first payment may be for more than one month’s cost because you will be billed prorated costs for the month in which your COBRA continuation coverage begins plus the full cost for the next month.

Your first payment must be made within 45 days after COBRA continuation coverage is elected.

NOTE: If you do not receive a payment notice from the myHR Service Center, it is your responsibility to contact the myHR Service Center and ensure that your full payment is received by the due date.

Full payments not received within 30 days after the premium is due (or, if later, 45 days after COBRA continuation coverage is elected) will result in loss of coverage retroactive to the day your premiums were paid through. Once coverage is terminated for non-payment, it cannot be reinstated.

In general, premium payments for COBRA continuation coverage change at the beginning of each new plan year.

SECOND QUALIFYING EVENTS/LENGTH OF COBRA CONTINUATION COVERAGE
Your qualified beneficiaries may extend coverage for up to 36 months (measured from the date of the initial qualifying event) if one of the following second qualifying events occurs and causes you to lose coverage while they are receiving COBRA continuation coverage:

- You die; or
- You and your spouse divorce or legally separate with a court order (whichever occurs earlier); or
- You and your domestic partner dissolve the partnership; or
- You become entitled to Medicare; or
- Your child becomes ineligible for Plan coverage.

NOTE: You may not elect COBRA continuation coverage on behalf of a divorced spouse or former domestic partner, but he or she may personally elect to continue coverage. If your request for an extension is rejected, the myHR Service Center will notify you within 14 days of receiving your request.
To be offered COBRA continuation coverage for divorce, legal separation, dissolution of the domestic partnership, your becoming entitled to Medicare, or loss of dependent status, you or your dependents must notify the myHR Service Center within 60 days of a second qualifying event (or within 60 days of the date coverage would cancel because of the second event, if later).

**SPECIAL RULES FOR DISABLED QUALIFIED BENEFICIARIES**

If you or a covered dependent (who was originally eligible for and elected COBRA continuation coverage) was disabled for Social Security purposes before or within 60 days after the date that your employment ended or your hours were reduced, the COBRA continuation coverage period may be extended for you and your qualified beneficiaries until 29 months from the initial qualifying event or the end of the month following the month in which the disabled individual ceases to be disabled, whichever is earlier. Your COBRA continuation coverage period also may be extended if a child born to, placed for adoption with, or adopted by you during the period you are receiving COBRA continuation coverage becomes disabled for Social Security purposes within 60 days after the birth, adoption, or placement of that child for adoption.

To request an extension of COBRA continuation coverage, mail a copy of the disabled participant’s Social Security Disability Award Letter to the myHR Service Center:

- Within 60 days of the COBRA continuation coverage notice, if the Award Letter was issued **before** you lost coverage because your employment ended or your hours were reduced; or
- Within 60 days of the date of the Award Letter **and** before the end of the first 18 months of the COBRA continuation coverage period, if the Award Letter was issued **after** you lost coverage because your employment ended or your hours were reduced.

If your request for an extension is rejected, the myHR Service Center will notify you within 14 days of receiving your request.

**NOTE:** If the Social Security Administration subsequently determines that the disabled participant is no longer disabled, the myHR Service Center must be notified **within 30 days** of the Social Security Administration’s final determination.

**Costs for Disabled Qualified Beneficiaries**

Your COBRA continuation coverage premium will increase to 150% of the cost of coverage for active employees for any period that the disabled individual receives COBRA continuation coverage, generally beginning with the 19th month of COBRA continuation coverage and continuing until COBRA continuation coverage terminates. That means that, generally, for the first 18 months of COBRA continuation coverage, you would pay 102% of the Plan’s cost of coverage monthly, and for any portion of the remaining coverage period during which the disabled individual receives COBRA continuation coverage, you would pay 150% of the Plan’s cost of coverage monthly.

If you incur a second qualifying event during the disability extension period and extend your coverage to the maximum of 36 months from the first qualifying event, you will continue to pay at the 150% rate through the 36th month if you continue COBRA continuation coverage of the disabled individual. However, if the second qualifying event occurs within the original COBRA continuation coverage period (generally 18 months), you will not be charged more than 102% of the Plan’s cost of coverage at any time during the COBRA continuation coverage period.

**NOTE:** If you elect to continue COBRA continuation coverage but the disabled individual does not elect COBRA continuation coverage, your premiums will remain at 102% of the Plan’s cost of coverage for the entire 29-month period.
MEDICARE EXTENSION FOR DEPENDENTS
If, within 18 months of becoming entitled to Medicare, you start to receive COBRA continuation coverage, your covered spouse and dependents may extend COBRA continuation coverage up to 36 months (measured from the date you became entitled to Medicare). You must notify the myHR Service Center within 60 days of a second qualifying event.

LOSS OF COBRA CONTINUATION COVERAGE
COBRA continuation coverage for you or your covered dependents may stop before the maximum coverage period ends if:

- You (or your covered dependent) do not pay the full monthly premium for the coverage within 30 days of its due date (or within 45 days, if it is the initial monthly payment);
- You (or your covered dependent) become covered after the date you elect COBRA continuation coverage under any other like-kind group health plan, and
  — The other plan has no exclusions or limitations regarding that participant’s own pre-existing conditions (if any), or
  — The participant is not subject to the other plan’s exclusions or limitations;
- The Company stops providing any group health coverage to its employees;
- Coverage was extended for up to 29 months due to a covered participant’s disability, and it is determined that the covered participant is no longer disabled;
- You (or your covered dependent) voluntarily cancel coverage; or
- You (or your covered dependent) die. If you die, your qualified beneficiaries may extend COBRA continuation coverage for up to 36 months, measured from the date of the initial qualifying event. If COBRA continuation coverage stops before the end of the maximum coverage period, you will receive a written notice explaining why COBRA continuation coverage ended early, the date COBRA continuation coverage ended, and any rights you have under the Plan or applicable law to other group or individual coverage.

For COBRA purposes, you are entitled to Medicare if you are eligible for Medicare and are actually enrolled in Medicare. If you have to take additional steps to enroll in Medicare before receiving benefits, you are not yet entitled to Medicare for purposes of COBRA. Generally, you are automatically entitled to Medicare Part A if you have already applied for and are receiving Social Security benefits.
COBRA CONTINUATION COVERAGE ELIGIBILITY/PARTICIPATION APPEALS

If you believe that your request for or participation in COBRA continuation coverage has been administered incorrectly, call the myHR Service Center at 1-888-884-6947 to speak with a myHR Service Center Representative.

The myHR Service Center Representative will discuss your eligibility and/or participation issue with you and make a determination. If you disagree with the myHR Service Center Representative’s determination, you will be transferred to the myHR Service Center Manager for additional assistance. If you disagree with the Manager’s determination, you may appeal the eligibility and/or participation issue up to two levels. The appeals process is described below.

Level I Eligibility/Participation Appeal

To file a first level review of the myHR Service Center Manager’s determination, you must request a Level I Eligibility/Participation Appeal Form from the Manager.

Upon request, the Manager will mail you a Level I Eligibility/Participation Appeal Form within three business days.

You must send the completed and signed Level I Eligibility/Participation Appeal Form and copies of any documents or records that support your request to the address listed on the form.

You must send your first written appeal (Level I) to the myHR Service Center within 60 days of the statement date on Page 1 of the Level I Eligibility/Participation Appeal Form.

If you do not send the Level I appeal within the 60-day period, your appeal will not be reviewed and you will forfeit any right to any further review of your eligibility and/or participation issue.

If you timely file your appeal but it cannot be processed because, for example, you did not follow the correct procedures for filing an appeal, the Benefit Determination Review Team (the “Team”) will notify you, in writing, as soon as possible and tell you what steps you must take to have your request reviewed.

You will usually receive written notice of the Team’s decision within 30 days of the date the Team receives your appeal. You will be notified if special circumstances require more than 30 days. In no case will the review process take longer than 60 days from the date the Level I appeal was received by the Team. If you are requested to provide additional information to process your appeal, you will have 45 days to provide the additional information. (The actual due date is stated in the notice.) The days from the date you are sent the notice to the due date for the requested information (or, if earlier, the date you respond to the request) will not be counted as part of the time by which the Team must make a decision on your appeal. If you do not send the additional information by the due date, your claim will be reviewed without the information.

If your appeal is denied, the written notice will explain the reasons for the denial and provide you with instructions on how to submit a Level II Eligibility/Participation Final Appeal if you are not satisfied with the Level I review.

Level II Eligibility/Participation Final Appeal

If you are not satisfied with the first level review, you may submit a Level II written appeal directly to the Company within 60 days after receiving the Level I denial letter. The denial letter will include instructions on how to submit a Level II appeal. A Level II appeal should be mailed to:

Marriott International, Inc.
Benefits Department 52-935.62
10400 Fernwood Road
Bethesda, MD 20817

Your final appeal (Level II) letter should include the following:

• Reasons for the appeal; and

• Copies of any documents or records that support your position.
The Plan Administrator will review your Level II appeal and make a final decision. You will usually receive written notice of this decision within 60 days of the date the Plan Administrator receives your appeal. You will be notified if special circumstances require more than 60 days. In no case will the review process take longer than 120 days from the date your Level II appeal was received by the Plan Administrator.

The Plan Administrator has full discretionary authority to interpret the provisions of the Plan with respect to eligibility and participation. All decisions of the Plan Administrator are final and binding on all parties.

NOTE: If you hear nothing within 60 days from the date you requested a review, contact the Plan Administrator to make sure your appeal was received.

QUESTIONS ABOUT COBRA CONTINUATION COVERAGE
If you have questions about COBRA continuation coverage and you are an active employee, visit the myHR Web site at www.4myHR.com or call the myHR Service Center at 1-888-884-6947 (1-888-884-6947).

If you are a former employee, spouse, or dependent child who is no longer eligible for active coverage, access the Web site through www.marriottbenefits.com, rather than through the Web site listed above.

INFORMATION ON TAX CONSEQUENCES FOR DOMESTIC PARTNERS OR SAME-SEX SPOUSES

DOMESTIC PARTNERS WHO ARE NOT YOUR TAX DEPENDENT
If your domestic partner is not your tax dependent, federal law may require you to pay additional federal and/or state and local taxes in order to maintain medical, dental, and/or vision coverage for your domestic partner.

SAME-SEX SPOUSES
Generally, for federal income and FICA taxes, the cost of coverage for your same sex spouse will be treated like an opposite-sex spouse. Your marriage is considered valid based on the jurisdiction where it was celebrated. If the state where you live follows the federal rule, state or local tax adjustments will not be required. However, if the state where you live does not recognize same-sex marriages for tax purposes, then the state and local income tax rules discussed below may apply to you.

CHILDREN
Generally, eligible children of your domestic partner and same sex spouse are subject to similar special tax considerations to those described in this section.

The following examples, applicable to domestic partners and same-sex spouses (who lives in states that do not recognize same-sex marriages for tax purposes), are for illustration only. Your actual amounts may be more or less than the amounts shown.

TAXABLE COMPANY CONTRIBUTION
Company contributions to your domestic partner’s or same-sex spouse’s (who lives in states that do not recognize same-sex marriages for tax purposes) coverage will be considered taxable income to you.

The taxable amount will equal the difference between the amount the Company contributes for “You Only” coverage and the amount the Company contributes for “You + Spouse” coverage.
NOTE: Actual contribution amounts vary by option. The contribution amounts used in the following charts are for illustration purposes only.

### ILLUSTRATION 1

| Contribution for “You + Spouse” coverage | $77.76 |
| Contribution for “You Only” coverage     | $39.22 |
| Taxable amount                           | $38.54 |

**TAXABLE EMPLOYEE CONTRIBUTION**

Regardless of how you elect to pay for your coverage, you will have to pay for your domestic partner’s coverage or same sex spouse’s (who lives in states that do not recognize same-sex marriages for tax purposes) coverage with after tax dollars.

**If You Have Elected Before-Tax Contributions for Your Coverage**

If you pay for your own coverage with before-tax dollars, you still must pay for your domestic partner’s or same-sex spouse’s (who lives in states that do not recognize same-sex marriages for tax purposes) coverage on an after-tax basis. The portion of your contribution attributed to your domestic partner or same-sex spouse will be deducted from your paycheck on an after-tax basis. The taxable amount for your domestic partner’s or same-sex spouse’s coverage will equal the difference between the amount you contribute for “You Only” coverage and the amount you contribute for “You + Spouse” coverage.

### ILLUSTRATION 2

| Contribution for “You + Spouse” coverage       | $40.16 |
| Contribution for “You Only” coverage           | $20.21 |
| Taxable amount                                 | $19.95 |

In this illustration, $20.21 would be deducted from your paycheck on a before-tax basis, and $19.95 would be deducted on an after-tax basis (a total paycheck deduction of $40.16).

**If You Have Elected After-Tax Contributions for Your Coverage**

If you pay for your own coverage with after-tax dollars, the total paycheck deduction of $40.16 would be deducted on an after-tax basis.

**WHAT WILL SHOW ON YOUR PAYCHECK**

If your medical, dental and vision coverage is taxable:

- The Company’s contributions will appear as imputed income on your paycheck. The Company’s contributions to your domestic partner’s coverage will be considered taxable income to you and will be subject to Social Security and federal income tax withholding. State and local taxes also may be applied.

This amount will be reported to the IRS and other state and local taxing authorities as part of your wages on each pay stub, and additional income taxes and FICA taxes will be withheld from your paycheck on this “imputed income.”
Your same-sex spouse (who lives in states that do not recognize same-sex marriages for tax purposes) also will have taxable “imputed income” on their paycheck that will be reported to state and local tax authorities.

- Your paycheck will include a “TAX INS” entry to show the portion of the Company’s contribution to your domestic partner’s or same-sex spouse’s coverage that results in imputed income ($38.54 in Illustration 1).
- The Company’s payroll system can only reflect “You + Spouse,” “You + Child(ren),” and “You + Family” coverage as purchased on either an entirely before-tax or after-tax basis. Therefore, if you pay for your own coverage on a before-tax basis, you will see a before-tax deduction for the full amount of your “You + Spouse” or “You + Family” coverage along with an increased “TAX INS” entry on your paycheck. To properly tax your domestic partner’s or same-sex spouse’s benefits, your “TAX INS” entry will reflect both the portion of the Company contribution to your domestic partner’s or same-sex spouse’s coverage and the portion of the domestic partner or same-sex spouse premium that you must pay on an after-tax basis.

<table>
<thead>
<tr>
<th>ILLUSTRATION 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Taxable Company contribution</td>
<td>$38.54 (Illustration 1)</td>
</tr>
<tr>
<td>Domestic partner premium</td>
<td>$19.95 (Illustration 2)</td>
</tr>
<tr>
<td>“TAX INS” amount</td>
<td>$58.49</td>
</tr>
</tbody>
</table>

**NOTE:** The total imputed (taxable) income will appear on your paycheck listed as “TAX INS.” You will also see the actual deductions for the cost of the benefits.

Taxable income will continue to accrue even if you are not receiving a paycheck, and the tax due will be deducted from your next available paycheck. For example, if you take an unpaid leave of absence, the tax owed on this imputed income will be deducted from your first paycheck upon your return to work.

**PERMITTED BEFORE-TAX COVERAGE**

If your domestic partner or same-sex spouse (qualifies as your federal tax dependent, the amount the Company pays toward your domestic partner’s or same-sex spouse’s coverage will not be taxable to you and will not result in any additional federal income or FICA taxes.

You also have a choice of paying for your domestic partner’s or same-sex spouse’s coverage on a before-tax or an after-tax basis. You and your domestic partner or same-sex spouse (and/or his or her eligible dependents) must enroll on the same tax basis.

**IF YOU MARRY**

If you and your domestic partner legally marry, you should contact the myHR Service Center within 31 days of the marriage and your domestic partner’s status will be changed to “spouse” retroactive to the date of the event. In addition, your imputed income will be adjusted accordingly.

If you report you and your domestic partner’s legal marriage to the myHR Service Center more than 31 days after the event, your domestic partner’s status will be changed to “spouse” effective as of the date of your call. In this case, your imputed income will not be adjusted retroactively; rather, it will stop as of your next paycheck. In this situation, there could be a delay of one paycheck due to the timing of your call.
NOTE: If you and your domestic partner later marry, you must call the myHR Service Center within 31 days of the date of marriage to update your domestic partner’s tax status.

YOUR RIGHTS

PLAN ADMINISTRATION
The following plans are sponsored by Marriott International, Inc., 10400 Fernwood Road, Bethesda, MD 20817:

- BlueCross BlueShield PPO
- Health Maintenance Organizations
- Aetna Select Open Access (Gold)
- Aetna Choice POS II (Silver)
- Aetna Choice POS II (Bronze)
- CIGNA Open Access Plus In-network (Gold)
- CIGNA Open Access Plus (Silver)
- CIGNA Open Access Plus (Bronze)
- Select Med HMO (Gold)
- Comprehensive Vision Plan
- Dental
- Hawaii Dental
- Hawaii Medical Programs
- New York Dental
- Hourly Short-Term Disability (HSTD) Plan
- Salaried Short-Term Disability (SSTD) Plan
- Long-Term Disability (LTD) Plan (Hourly Long-Term Disability [HLTD] and Salaried Long-Term Disability [SLTD])
- Group Term Life (GTL) Insurance (Free Life and Additional Life)
- Accidental Death & Dismemberment (AD&D) Plan
- Business Travel Accident Insurance (BTA)
- Spending Accounts (Health Care Spending Account [HCSA] and Dependent Care Spending Account [DCSA])
- Severance Plan
- myARL Assistance Program and Work-Life Services
- Death Benefit Plan
The Plan Administrator, as a named fiduciary, has authority to control and manage the operation and administration of the Plan in accordance with the Plan document.

The plans listed above are welfare benefit plans intended to provide specified benefits to participating employees under the terms of the plans.

Marriott International, Inc. has designated Edward A. Ryan, Executive Vice President and General Counsel of Marriott International, Inc., as the agent for service of legal process. Mr. Ryan’s address is Marriott International, Inc., 10400 Fernwood Road, Bethesda, MD 20817. The Plan Trustee, for all plans except for the Severance Plan and Business Travel Accident Plan, is Carolyn B. Handlon, Executive Vice President and Global Treasurer, Marriott International, Inc., 10400 Fernwood Road, Bethesda, MD 20817. Service of legal process may also be made upon the Plan Trustee (if the plan has a trust) or Plan Administrator.

The Benefits Department of Marriott International, Inc. acts as the Plan Administrator.

The plans listed in this section are either Self-Funded or insured. Also, benefits are financed through contributions from either participants and/or the Company. Below is a chart illustrating, for each plan, whether the plan is Self-Funded or insured (and insured by whom), who contributes to the plan, and the plan’s Identification Number:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Self-Funded or Insured</th>
<th>Contributions</th>
<th>Plan ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Select Open Access (Gold)</td>
<td>Self-Funded</td>
<td>Company and employee</td>
<td>501</td>
</tr>
<tr>
<td>Cigna Open Access Plus In-Network (Gold)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Select Med HMO (Gold)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BlueCross BlueShield PPO</td>
<td>Self-Funded</td>
<td>Company and employee</td>
<td>501</td>
</tr>
<tr>
<td>Aetna Choice POS II (Silver)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cigna Open Access Plus (Silver)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna Choice POS II (Bronze)</td>
<td>Self-Funded</td>
<td>Company and employee</td>
<td>501</td>
</tr>
<tr>
<td>Cigna Open Access Plus (Bronze)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Maintenance Organizations</td>
<td>Funded through payments to the individual HMOs</td>
<td>Company and employee</td>
<td>501</td>
</tr>
<tr>
<td>Hawaii Medical Programs</td>
<td>Funded through payments to the individual programs</td>
<td>Company and employee</td>
<td>501</td>
</tr>
<tr>
<td>Comprehensive Vision Plan</td>
<td>Insured by Combined Insurance Company of America</td>
<td>Employee only</td>
<td>581</td>
</tr>
<tr>
<td>Dental</td>
<td>Self-Funded</td>
<td>Company and employee</td>
<td>521</td>
</tr>
<tr>
<td>New York Dental Care Plan</td>
<td>Insured by Anthem Blue Cross and Blue Shield</td>
<td>Company and employee</td>
<td>521</td>
</tr>
<tr>
<td>Hawaii Dental</td>
<td>Insured by Hawaii Dental Service (HDS)</td>
<td>Company and employee</td>
<td>521</td>
</tr>
<tr>
<td>Hourly Short-Term Disability (HSTD) Plan</td>
<td>Self-Funded</td>
<td>Company and employee</td>
<td>502</td>
</tr>
<tr>
<td>Plan</td>
<td>Self-Funded or Insured</td>
<td>Contributions</td>
<td>Plan ID Number</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Salaried Short-Term Disability (SSTD) Plan</td>
<td>Insured by Aetna Life Insurance Company</td>
<td>Employee only</td>
<td>575</td>
</tr>
<tr>
<td>Long-Term Disability (LTD) Plan (Hourly Long-Term Disability [HLTD] and Salaried Long-Term Disability [SLTD])</td>
<td>Insured by Aetna Life Insurance Company</td>
<td>Employee only</td>
<td>503</td>
</tr>
<tr>
<td>Group Term Life (GTL) Insurance</td>
<td>Insured by Aetna Life Insurance Company</td>
<td>Trust reserves (Free Life) Employee only (Additional Life)</td>
<td>508</td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment (AD&amp;D) Plan</td>
<td>Insured by NUFIC</td>
<td>Employee only</td>
<td>505</td>
</tr>
<tr>
<td>Business Travel Accident (BTA) Plan</td>
<td>Insured by NUFIC</td>
<td>Company only</td>
<td>580</td>
</tr>
<tr>
<td>Spending Accounts (Health Care Spending Account [HCSA] Plan)</td>
<td>Self-Funded</td>
<td>Employee only</td>
<td>551</td>
</tr>
<tr>
<td>Spending Accounts (Dependent Care Spending Account [DCSA] Plan)</td>
<td>Self-Funded</td>
<td>Employee only</td>
<td>541</td>
</tr>
<tr>
<td>Severance Plan</td>
<td>Self-Funded</td>
<td>Company only</td>
<td>542</td>
</tr>
<tr>
<td>myARL Assistance Program and Work-Life Services</td>
<td>Self-Funded</td>
<td>Company only</td>
<td>543</td>
</tr>
<tr>
<td>Death Benefit Plan</td>
<td>Self-Funded</td>
<td>Company only</td>
<td>570</td>
</tr>
</tbody>
</table>

Participants contribute to the cost of the plans through payroll deductions. For plans that have a trust, participant contributions are held in trust by the Treasurer of Marriott International, Inc. The Company contributes from its general assets to the trust whatever funds are necessary, if any, to meet plan expenses in excess of the amount contributed by participants.

Any questions you may have or information you require concerning your benefits, rights, and privileges in the Plan can be obtained by contacting the Plan Administrator as follows:

Marriott International, Inc.
Benefits Department 52-935.62
10400 Fernwood Road
Bethesda, MD 20817
1-301-380-4169

Only the Plan Administrator or officially designated representatives are authorized to speak for the Plan.

Except as otherwise noted, all Plan records are kept on a plan year basis, which is the calendar year (January 1 through December 31).

Marriott International, Inc.’s Employer Identification Number is 52-2055918.

Marriott International, Inc. reserves the right to discontinue any of the plans at any time. If a plan is discontinued, coverage for employees will cease at the end of the last pay period in which employee contributions were deducted, except as otherwise provided under the terms of the individual plan. Any
assets that remain, including funds that participants have contributed, will be used to pay benefits for outstanding claims as directed by Marriott International, Inc. Payments will stop when those funds have been disbursed.

RIGHTS OF PARTICIPANTS
As a participant in the Plan, you are entitled to rights and protection provided by the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, all Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator’s office and upon 10 days notice at any location where 50 or more participants customarily work, all Plan documents, including insurance contracts and, if applicable, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor;
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies;
- Receive a summary of the Plan’s annual financial report, a copy of which by law must be furnished by the Plan Administrator to each participant;
- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this SPD and the Plan documents on the rules governing your COBRA continuation coverage rights; and
- A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage under another plan. You will be provided with a certificate of creditable coverage, free of charge, when you (or your dependents) lose coverage under the Plan, when you (or your dependents) become ineligible for COBRA continuation coverage, and upon request when made within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new plan.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called “named fiduciaries,” have a duty to do so prudently and in the interest of all Plan participants and beneficiaries.

No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time periods.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the Plan’s latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless they were not sent for reasons beyond the Plan Administrator’s control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

Also, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If the Plan’s fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file a suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay court costs and legal fees if it finds your claim is frivolous.
Upon written request, the Plan Administrator will furnish any Plan participant with information as to whether a particular subsidiary and/or division is included in the Plan and, if so, the subsidiary’s and/or division’s address.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272 or by logging on to the Internet at www.dol.gov/ebsa.
AN IMPORTANT NOTICE
ABOUT YOUR PROTECTED HEALTH INFORMATION

Federal law, under the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”), has established national standards for protecting the privacy of individuals' medical records and protected health information (“PHI”). These privacy rules generally require covered entities, such as Marriott’s group health plans, to establish safeguards for the use or disclosure of, and requests for, PHI.

As the sponsor for various health plans, Marriott has always been committed to ensuring that the health information of its plan participants is handled in a confidential and appropriate manner. In its continuing effort to maintain the integrity of its plans, Marriott will take the steps necessary to comply with the new legal requirements on information privacy.

To ensure you understand these privacy rules, HIPAA requires the individuals responsible for Marriott’s health plans to inform plan participants about certain ways their PHI may be used and of their rights under the privacy law. The "Notice of Privacy Practices" that follows is the Marriott plan administrator's notice to you and your eligible dependents. Read it carefully and keep a copy with your plan materials. If you ever need an additional copy of the notice, you can obtain it in the following ways:

- Call 1-888-88-4myHR (1-888-884-6947). Representatives are available between 9 a.m. and 8 p.m Eastern time, Monday through Friday.

- Use the web site www.4myHR.com.

- If you are no longer working at Marriott, go to www.marriottbenefits.com.

- Ask for a copy at your work place.

NOTA: Para obtener una version en Espanol de esta informacion, llame al 1-888-88-4myHR.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("notice") describes the legal obligations of the group health plans sponsored by Marriott International, Inc. and your legal rights regarding your protected health information held by the plans under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). Among other things, this notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

This notice applies to the Marriott International, Inc. Medical Plan, the Marriott International, Inc. Dental Plan, the Marriott International, Inc. Health Care Spending Account Plan and the Employee Assistance Program (individually referred to as the "Plan" and collectively as the "Plans"). These Plans participate in an organized health care arrangement. As such, the Plans may share your medical information with each other and may use and disclose your medical information for treatment, payment and health care operations. NOTE: If you participate in an HMO or insured arrangement, you may also receive a separate notice from the HMO or insurer.

The Plans are required by law to maintain the privacy of your protected health information, give you this notice of the legal duties and privacy practices with respect to the protected health information that the Plans collect and maintain, and to follow the terms of the notice currently in effect.

The Plans reserve the right to change the terms of this notice and to make new provisions regarding your health information that the Plans maintain, as allowed or required by law. If the Plans make any material changes to this Notice, a copy of the new Notice will be posted on www.4myHR.com and the MGS portal by the effective date of the material change, and sent by the Marriott Benefits Department to you in the next annual open enrollment mailing.

Effective Date: This Notice is effective September 23, 2013.

How the Plans May Use and Disclose PHI

Protected health information ("PHI") refers to information that identifies you and relates to your health, treatment and payment for health care services. PHI may include, but is not limited to:

- Your name, social security number and contact information;
- Your medical history, conditions, treatments and medication;
- Your healthcare claims, health plan account numbers, bills and insurance information; and
- Demographic information such as your age, gender, ethnic and occupation.

The following categories describe different ways that the Plans may use and disclose PHI without your permission. For most categories of uses or disclosures, an explanation and example is provided. Not every use or disclosure in a category is listed.

For Treatment: The Plans may use or disclose your PHI so that doctors and other health care personnel can provide you treatment and services. For example, the Plans may disclose medical records to your physician to help diagnose and treat you for a medical condition.

For Payment: The Plans may use and disclose PHI to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. The Plans may also share medical information with a utilization review or precertification service provider. Likewise, the Plans may share medical information with another entity to assist with the adjudication or subrogation of health claims or to
another health plan to coordinate benefit payments. For example, the Plans may give your health care provider information concerning your coverage levels so that the provider may charge you and the Plans the correct rate for services provided.

**For Health Care Operations:** The Plans may use and disclose your PHI for health care operations to maintain the quality of services under the Plans you select. For example, the Plans may use or disclose your PHI in order to conduct or arrange for medical review, legal services and auditing functions, including peer review to determine whether health services were necessary and reasonably priced. The information also may be used for plan improvement analyses, such as formulary development and the development of improved payment methods.

**Disclosures to Business Associates and Other Covered Entities:** Some services are provided through contracts with business associates or other covered entities, and your PHI may be disclosed to them to allow them to perform services related to Plan administration. Examples include auditors, consultants, and copy services used to make copies of your health record. The Plans will require its business associates to agree in a written contract to appropriately safeguard PHI and to limit the use and disclosure of PHI. Business associates also have direct legal obligations to safeguard PHI.

**Communication with Family or Other Persons Involved in Your Care:** Your PHI may be disclosed in order to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition. In addition, the Plan administrators or their delegates, using their best judgment, may disclose PHI to a family member, other relative, close personal friend or any other person you identify who is involved in your care or in the payment related to your care. If you are present, the Plans will give you the opportunity to object before disclosing your PHI to these persons. If you are incapacitated or in an emergency, the Plans may disclose your PHI to these persons if it is determined that the disclosure is in your best interest.

**Organ and Tissue Donation:** If you are an organ donor, the Plans may release your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Workers Compensation:** Your PHI may be disclosed to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

**Threat to Health and Safety:** The Plans may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plans may disclose PHI about you in a proceeding regarding the licensure of a physician.

**Health Oversight Activities:** The Plans may disclose your PHI to a government agency or its contractors authorized to oversee the health care system or government benefit programs, and to public health authorities for public health purposes. Oversight activities can include audits, investigations, inspections, and licensure.

**Public Health Activities:** The Plans may disclose your PHI to appropriate authorities for the following reasons: (i) to prevent or control disease, injury, or disability; (ii) to report births and deaths; (iii) to report child abuse and neglect; (iv) to report reactions to medications or problems with products; (v) to notify people of recalls of products they may be using; (vi) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; (vii) to notify the appropriate government authority if the Plans reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes; and (viii) to notify schools about a student’s immunization records, if the student’s parents or guardian agrees to the disclosure.
Law Enforcement and Legal Compliance or Disputes: Under certain circumstances, the Plans may disclose your PHI --

- in response to a court order, subpoena, warrant, summons or similar process. (For example, the Plans may receive a qualified medical child support order requiring you to cover an individual as a dependent under your coverage);
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, the Plans are unable to obtain the victim’s agreement;
- about a death that may be the result of criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: The Plans may release PHI to a coroner or medical examiner to identify a deceased person, determine the cause of death or permit the coroner or medical examiner to carry out other duties as authorized by law. The Plans may also release PHI about patients to funeral directors as necessary to carry out their duties.

Correctional Institution: If you are an inmate of a correctional institution, the Plans may disclose to the institution or its agents, PHI for your health, the health and safety of other individuals, or for the safety and security of the correctional institution.

Required by Law: The Plans may use or disclose your PHI when required to do so by law. For example, the Plans must disclose your PHI to the U.S. Department of Health and Human Services upon request for purposes of determining whether the Plans are in compliance with the HIPAA privacy rule.

Military and National Security: The Plans may disclose to military authorities the PHI of armed forces personnel under certain circumstances. The Plans may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities.

To the Company as Plan Sponsor: The Plans may disclose PHI to certain designated employees of Marriott International, Inc., the plan sponsor of the Plans. However, those employees will only use or disclose that information as necessary to perform plan administration functions (for example, if you file an appeal of a claim) or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization. The Plans may also disclose your enrollment information to the Plan Sponsor for payroll processes. In addition, the Plans may provide summary information stripped of demographic information about Plan participants to the Company to use to obtain premium bids for the coverage offered through the Plans or to make decisions regarding amendments to the Plans. The summary information the Plans may disclose summarizes: claims history, claims expenses, or types of claims experienced by the Plan participants.

Underwriting: The Plans may use or disclose your PHI for underwriting purposes. The Plans are prohibited, however, from using or disclosing PHI that is genetic information for underwriting purposes, except for purposes of underwriting related to a long-term care policy.

Your Authorization: Other uses and disclosures of your PHI not covered by this notice or the laws that apply will be made only with your written permission. Generally, the Plans will need to obtain your written authorization for uses and disclosures relating to psychotherapy notes, marketing, sale and receiving remuneration for your PHI. If you provide the Plans authorization to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, the Plans will no longer use or disclose your PHI except to the extent that any authorized disclosures have already been made.

Your Rights
Although your health record is the physical possession of the healthcare practitioner or entity that compiled it, the PHI belongs to you. You have the rights described below.

- **The right to access your information.** You have the right to look at or get copies of your medical information, with limited exceptions. Such requests must be in writing to the address indicated under “Contact” below. You may request that the Plans provide copies of records in our possession in a format other than photocopies. The Plans will use the format you request unless impracticable. If you agree, a summary or explanation of the PHI will be provided instead of the full set of data. You also have the right to access your own e-health record in an electronic format and to direct the Plan to send the e-health record directly to a third party. A fee may be charged for copying, postage or preparing a summary of PHI.

- **The right to request restrictions on certain uses and disclosures of PHI.** You have the right to request restrictions on the use and disclosure of PHI. Please note, except in limited circumstances, the Plans are not required to agree to a requested restriction. In addition, if emergency care is required, the Plans may temporarily disregard an approved restriction.

- **The right to request confidential communications.** You have the right to request that the Plans communicate with you in confidence about your PHI by alternative means or to an alternative location. The Plans will accommodate your request if you clearly, and in writing, state that the disclosure of your PHI by the usual means could endanger you. The Plans must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit the Plans to administer your health plan benefits, including issuance of explanations of benefits. Before accommodating your request, the Plans may require you to explain how you will meet your payment obligation.

- **The right to amend PHI.** You have the right to have a covered entity amend PHI or a record about you in a designated record set. Requests to amend should be submitted to the appropriate covered entity. Requests made to the Plans to amend PHI must be made in writing and include a reason to support the requested amendment. The Plans may deny your request in certain situations. If the Plans deny your request, you have the right to file a statement of disagreement with the Plans and any future disclosures of the disputed information will include your statement.

- **The right to receive an accounting of the disclosures of PHI.** You have the right to receive a list of instances in which the Plans or its business associates disclosed your PHI for purposes other than for treatment, payment, health care operations, and limited other activities. You are entitled to such an accounting for the six years prior to your request. The Plans will provide you with the date on which the Plans made a disclosure, the name of the person or entity to whom the Plans disclosed your medical information, a description of the PHI disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, the Plans may charge you a reasonable, cost-based fee for responding to these additional requests. Special circumstances also may prevent the release of the information (for example, national security issues).

- **The right to be notified of a breach.** You have the right to be notified in the event that the Plans (or a Business Associate) discover a breach of unsecured PHI.

**State Laws**

The Department of Health and Human Services may determine that your state laws provide additional rights concerning the protection of PHI than indicated in this notice.

**For More Information**
If you have questions or want additional information contact the Plan Administrator at:

Plan Administrator
Marriott International, Inc.
Benefits Department 52-935.62
10400 Fernwood Rd.
Bethesda, MD 20817
Phone (301) 380-4169

**Reporting a Problem**

If you believe your privacy rights have been violated, you may file a complaint with the privacy office at the address indicated below or the Office for Civil Rights of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

**Contact**

If you wish to exercise your rights under this notice, contact the privacy office at:

Marriott International, Inc.
Attention: Privacy Officer
Dept. 52/996.19
10400 Fernwood Road
Bethesda, MD 20817
Phone: (301) 380-3000
e-mail: privacy@marriott.com

You have the right to a paper copy of this notice. Copies of this notice may be obtained in the following ways:

- **Call 1-888-88-4myHR (1-888-884-6947).** Representatives are available between 9 a.m. and 8 p.m. Eastern time, Monday through Friday.

- **Use the web site [www.4myHR.com](http://www.4myHR.com).**

- **If you are no longer working at Marriott,** go to [www.marriottbenefits.com](http://www.marriottbenefits.com).

Ask for a copy at your work place.

**IMPORTANT HEALTH CARE REFORM INFORMATION**

Some language changes in response to recent changes to preventive services coverage and women’s preventive health coverage under the Federal Affordable Care Act (ACA) may not be included in the enclosed booklet. However, please note that Aetna and CVS/caremark are administering medical and outpatient prescription drug coverage in compliance with the applicable components of the ACA and the AMA.

Preventive services, as required by ACA, will be paid without cost-sharing such as payment percentages, copays and deductibles.
For details on any benefit maximums and the cost sharing under your plan, call your Aetna contact number on the back of your ID card.

IMPORTANT HEALTH CARE REFORM NOTICE

Choice of Provider

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

FOR MORE INFORMATION

If you have questions or want additional information contact the Plan Administrator at:

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Benefits Department 52-935.62
10400 Fernwood Rd.
Bethesda, MD 20817
Phone (301) 380-4169