STATE OF NEW JERSEY

AETNA MEMBER HANDBOOK

FOR EMPLOYEES AND RETIREES

ENROLLED IN THE

STATE HEALTH BENEFITS PROGRAM OR
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

Department of the Treasury
Division of Pensions and Benefits

PLAN YEAR 2011

Welcome!

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

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

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

An online version of this handbook containing current updates is available for viewing over the Division of Pensions and Benefits Web site at:
www.state.nj.us/treasury/pensions/health-benefits.shtml

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

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

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

We wish you the best of health.

How to Use Your Plan

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

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

Tips for New Plan Participants

- Keep this member handbook where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Post your Primary Care Physician's name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See "In Case of Medical Emergency" (on page 26) for emergency care guidelines.

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How the Plan Works

Aetna HMO is available to all employees and retirees *without* Medicare residing in Delaware, Florida, New Jersey, New York, Maryland and Pennsylvania. **Aetna Select** is available to retirees *without* Medicare residing *outside of* Delaware, Florida, New Jersey, New York, Maryland and Pennsylvania. Both plans offer quality coverage with the added benefit of low out-of-pocket costs. There are no claim forms to fill out and no deductible to pay.

Medicare-eligible Retirees enrolled in Aetna and their dependents who are eligible for Medicare are enrolled in the **Aetna Medicare Plan (HMO).** Members must reside in an Aetna Medicare Plan (HMO) service area. Aetna Medicare Plan (HMO) members have the same benefits and the same copayments as those enrolled in the HMO plan, but the Aetna Medicare Plan (HMO), not original Medicare, is the primary payer.

The Primary Care Physician

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

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

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

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

No referrals are needed when an Aetna Medicare Plan (HMO) member seeks care from a participating provider. Precertification may be required for some services. Retirees enrolled in the Aetna Medicare Plan (HMO) receive an identification card that indicates they are in the Aetna Medicare Plan (HMO). You should present your Aetna Medicare Plan (HMO) ID card, not your original Medicare ID card, when receiving medical services (see page 3 for more information).

Primary and Preventive Care

Your Primary Care Physician can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your Primary Care Physician. You may also obtain routine gynecological exams from participating providers without a referral from your Primary Care Physician. As a member of the HMO Plan, you are responsible for the applicable copayment. Members of the Aetna Medicare Plan (HMO) are not responsible for a copayment for routine preventive care.

Specialty and Facility Care

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

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

Follow these steps to avoid costly and unnecessary bills:

- **Consult your Primary Care Physician first** when you need routine medical care. If your Primary Care Physician deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. For direct access benefits, you may contact the participating provider directly, without a referral.
- Certain services require **both** a referral from your Primary Care Physician **and** prior authorization from Aetna. Your Primary Care Physician is responsible for obtaining authorization from Aetna for in-network covered services.
- **Review the referral** with your Primary Care Physician. Understand what specialist services are being recommended and why.
- Present the referral to the participating provider. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services**.
- If it is not an emergency and you go to a doctor or facility **without your** Primary Care Physician's **prior written or electronic referral, you must pay the bill yourself**.
- Your Primary Care Physician may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by Aetna in addition to a special nonparticipating referral from your Primary Care Physician. When properly authorized, these services are covered after the applicable copayment.

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

Provider Information

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

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

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

Your ID Card

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

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

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

Copayment Schedule

Unless otherwise indicated in the following chart, the **copayment for State employees is $15** per visit to a Primary Care Physician or referred specialist or facility.

The **copayment for Local Governmental,** and **Local Educational employees,** and **All Retirees** is **$10** per visit to a Primary Care Physician or referred specialist or facility.

All non-emergency specialty and hospital services require a prior referral from your Primary Care Physician, unless otherwise noted in the chart below as a "direct access" benefit.

Type of Service or Supply	Benefit Level
Maximum Benefit	Unlimited
Primary and Preventive Care	
PCP Office Visits	Copayment applies per visit
After Hours/Home Visits/Emergency Visits	Copayment applies per visit
Routine Examinations	Copayment applies per visit
Routine Child and Well-Baby Care	Copayment applies per visit
Immunizations	Copayment applies per visit
Routine Gynecological Exams – direct access (no referral) to participating provider – unlimited visits per calendar year	***HMO:*** Copayment applies per visit ***Medicare HMO:*** No copayment
Routine Mammogram – one annual mammogram for women age 40 and over – direct access (no referral)	No copayment
Prostate Screening – one annual prostate screening for men age 40 and over	***HMO:*** Copayment applies per visit ***Medicare HMO:*** No copayment
Routine Eye Examinations– direct access (no referral) to participating providers – one exam per 12 months	***HMO:*** Copayment applies per visit ***Medicare HMO:*** No copayment
Hearing Aids	Not covered – except for members 15 years old or younger
Specialty and Outpatient Care	
Specialist Office Visits	Copayment applies per visit
Prenatal Care: First OB visit Subsequent Prenatal Visits	 Copayment applies No copayment
Infertility Services: Diagnosis Treatment – with limitations	 Copayment applies per visit Copayment applies per visit
Advanced Reproductive Technology	Copayment applies per visit
Allergy Testing	Copayment applies per visit
Allergy Treatment – Routine injections at PCP's office, with or without physician encounter	Copayment applies per visit
Outpatient Facility Visits Chemotherapy Radiation Therapy Infusion Therapy	 No copayment No copayment Copayment applies per visit

Type of Service or Supply	Benefit Level
X-ray and Lab Tests	No copayment
Outpatient Therapy – Speech, Occupational, Physical	***HMO:*** Copayment applies per visit – limit of 60 visits per incident of illness or injury per calendar year ***Medicare HMO:*** Copayment applies per visit
Outpatient Cardiac Rehabilitation Therapy	Copayment applies per visit
Chiropractic Care	***HMO:*** Copayment applies per visit – limit of 20 visits per calendar year ***Medicare HMO:*** Copayment applies per visit
Home Health Care	No copayment
Hospice Care	No copayment
Durable Medical Equipment (DME)	***HMO:*** 100% after $100 DME deductible per calendar year – DME Out-of-Pocket Maximum $100 per individual, per calendar year ***Medicare HMO:*** No copayment
Prosthetic Devices	***HMO:*** 100% after $100 deductible per calendar year – combined deductible with DME (above) ***Medicare HMO:*** No copayment
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	No copayment
Skilled Nursing Facilities – 120 days per calendar year	No copayment
Hospice Facility	No copayment
Inpatient Visits	No copayment
Surgery and Anesthesia	
Inpatient Surgery	No copayment
Outpatient Surgery	No copayment
Mental and Nervous Conditions	
Inpatient Treatment – Non-Biologically Based Mental Illness	***HMO:*** No copayment – limit of 35 days per calendar year ***Medicare HMO:*** No copayment
Inpatient Treatment – Biologically Based Mental Illness – No maximum number of days	***HMO:*** No copayment ***Medicare HMO:*** No copayment
Outpatient Treatment – Non-Biologically Based Mental Illness	***HMO:*** Copayment applies per visit – limit of 30 visits per calendar year ***Medicare HMO:*** Copayment applies per visit
Outpatient Treatment – Biologically Based Mental Illness – No maximum number of visits	***HMO:*** Copayment applies per visit ***Medicare HMO:*** Copayment applies per visit

Type of Service or Supply	Benefit Level
Treatment of Alcohol and Drug Abuse	
Inpatient Treatment	***HMO:*** No copayment – limit of 28 days per occurrence ***Medicare HMO:*** No copayment
Inpatient Detoxification	***HMO:*** No copayment ***Medicare HMO:*** No copayment
Inpatient Rehabilitation	***HMO:*** No copayment – limit of 28 days per occurrence ***Medicare HMO:*** No copayment
Outpatient Treatment	***HMO:*** No copayment – limit of 60 visits per calendar year ***Medicare HMO:*** No copayment
Outpatient Detoxification	No copayment
Maternity	No copayment
Emergency Care	
Hospital Emergency Room Copayment waived if admitted	$50 copayment for State Employees $35 copayment for Local Employees and All Retirees $35 copayment for Aetna Medicare Plan (HMO)
Urgent Care Facility	$50 copayment for State Employees $35 copayment for Local Employees and All Retirees $35 copayment for Aetna Medicare Plan (HMO)
Ambulance	No copayment
HMO Prescription Drug Plan (Employees) – no annual maximum	
Retail (30-day supply)	$5 copayment – generic drugs $10 copayment – brand-name formulary drugs $20 copayment – brand non-formulary drugs
Mail Order (90-day supply)	$5 copayment – generic drugs $15 copayment – brand-name formulary drugs $25 copayment – brand non-formulary drugs
(Prescription coverage through the HMO Prescription Drug Plan may not be applicable to all employees)	

Type of Service or Supply	Benefit Level
HMO Prescription Drug Plan (State and Local Government Retirees)	
Retail (30-day supply)	$ 6 copayment – generic drugs $ 12 copayment – brand-name formulary drugs $ 24 copayment – brand non-formulary drugs
Mail Order (90-day supply)	$ 6 copayment – generic drugs $ 18 copayment – brand-name formulary drugs $ 30 copayment – brand non-formulary drugs
Annual Maximum Out-of-Pocket	$ 1,351 per person
HMO Prescription Drug Plan (Local Education Retirees)	
Retail (30-day supply)	$ 5 copayment – generic drugs $ 12 copayment – brand-name formulary drugs $ 24 copayment – brand non-formulary drugs
Mail Order (90-day supply)	$ 6 copayment – generic drugs $ 17 copayment – brand-name formulary drugs $ 29 copayment – brand non-formulary drugs
Annual Maximum Out-of-Pocket	$ 1,318 per person

Your Benefits

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

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

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

Primary and Preventive Care

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

Primary and Preventive services include:

- Office visits with your Primary Care Physician during office hours and during non-office hours.
- Home visits by your Primary Care Physician.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your Primary Care Physician. Routine physical examinations include, but are not limited to, employer-mandated physical examinations that are prerequisite to participation in a physical fitness test that is required as a condition of continuing employment.
- Well-child care from birth, including immunizations and booster doses, as recommended by your Primary Care Physician.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Routine gynecological examinations and Pap smears performed by your Primary Care Physician. You may also visit a participating gynecologist for a routine GYN exam and Pap smear without a referral.
- Annual mammography screening for asymptomatic women age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their Primary Care Physician.

  Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.
- Routine immunizations (except those required for travel or work).
- Annual eye examinations without a referral to a participating provider:
- Routine hearing screenings performed by your Primary Care Physician as part of a routine physical examination.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services. If you are an Aetna HMO Plan member, you must have a prior written or electronic referral from your Primary Care Physician in order to receive coverage for any non-emergency services the specialist or facility provides.

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

  There is a $36,000 dollar benefit maximum for ABA therapy services per year for children with autism. ABA therapy is <u>not</u> eligible for children with developmental diagnoses.

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

  Aetna HMO Utilization Management must be contacted for precertification by the provider requesting occupational therapy, speech, and physical therapy services.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.

- Emergency care including ambulance service – 24 hours a day, 7 days a week (see “In Case of Emergency” on page 26).
- Hearing Aids – Effective March 30, 2009, coverage will be provided for medically necessary expenses incurred in the purchase of a hearing aid for covered members who are 15 years old or younger. Coverage is provided for the purchase of a hearing aid for each hearing impaired ear once in a 24 month period, when it is medically necessary and prescribed by a licensed physician or audiologist. Benefits during each 24 month period are limited to the cost of the hearing aid up to $1,000 for each hearing impaired ear. If a higher priced hearing aid is selected, the member is responsible for the amount that is greater than $1,000.
- Home health services provided by a participating home health care agency, including:
  - Skilled nursing services provided or supervised by an RN.
  - Services of a home health aide for skilled care.
  - Medical social services provided or supervised by a qualified physician or social worker if your Primary Care Physician certifies that the medical social services are necessary for the treatment of your medical condition.

  - Outpatient hospice services include:

  - Counseling and emotional support.
  - Home visits by nurses and social workers.
  - Pain management and symptom control.
  - Instruction and supervision of a family member.
  - Patient care instruction

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

  - Bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
  - Homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
  - Respite care when the patient’s family or usual caretaker cannot, or will not, attend to the patient’s needs.
- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, removal of tumors and orthodontogenic cysts).
- Accidental dental injuries if medically necessary. You must have been covered by Aetna at the time the injury occurred. An accidental dental injury is considered an injury to teeth (must be sound natural teeth) which is caused by an external factor such as damage caused by being hit by a hockey puck or having teeth broken in a fall on the ice. The treatment and replacement must occur within 12 months of the accident. A treatment plan must be submitted. If it is determined that treatment cannot be reasonably completed within 12 months, this time limit <u>may be</u> extended. Breaking a tooth while chewing on food <u>is not</u> considered an accidental dental injury. Stress fractures in teeth are very common and generally undetectable by X-ray. Stress fractures are often the cause of tooth breakage. Treatment for this type of tooth breakage is considered a dental service and not eligible for reimbursement.

- Reconstructive breast surgery following a mastectomy, including:
  - Reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
  - Surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
  - Physical therapy to treat the complications of the mastectomy, including lymphedema.
- Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist. 20 visit calendar year maximum applies.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Prosthetics require preauthorization by Aetna.
- Inherited Metabolic Disease medical food, certain non-standard infant formula (under one year of age).
- Scalp Hair Prostheses – Maximum benefit of $500 in a 24 month period, per person, for scalp hair prostheses (wig) prescribed by a doctor, only if they are furnished in connection with hair loss resulting from:
  - Treatment of disease by radiation or chemicals;
  - Alopecia Universalis (totalis); or
  - Alopecia Areata.
- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury, and preauthorized by Aetna.

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

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

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice

If you are hospitalized by a participating Primary Care Physician or specialist (with prior referral except in emergencies), you are eligible for the following covered services listed below. See "Behavioral Health" on page 14 for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your Primary Care Physician) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.

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

Maternity

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

You do not need a referral from your Primary Care Physician for visits to your participating obstetrician. A list of participating obstetricians can be found in your provider directory or on DocFind (see "Provider Information" on page 3).

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

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

Infertility Treatment

Aetna will follow the New Jersey State Mandate for Infertility.

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

Eligibility Requirements

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

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

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

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

Covered Expenses

- Where a live donor is used in the egg retrieval, the medical costs of the donor shall be covered until the donor is released from treatment by the reproductive endocrinologist;

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

Exclusions

The following are specifically excluded infertility services:

- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Non-medical costs of an egg or sperm donor. Medical costs of donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist;
- Cryopreservation is not a covered benefit;
- Any experimental, investigational or unproven infertility procedures or therapies.
- Payment for medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by the carrier's policy or contract;
- Ovulation kits and sperm testing kits and supplies; or
- In vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer for persons who have not used all reasonable less expensive and medically appropriate treatments for infertility, who have exceeded the limit of four covered completed egg retrievals, or are 46 years of age or older.

Behavioral Health

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

Mental Health Treatment

The Plan covers the following services for mental health treatment:

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

Treatment of Alcohol and Drug Abuse

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

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

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

Biologically Based Mental Illnesses

Services rendered for the treatment of a **biologically-based mental illness** are treated like any other illness and are not subject to the mental health maximums. The law defines biologically based mental illness as a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Aetna recognizes the following as biologically based illnesses: Schizophrenia, Schizoaffective disorder, Major depressive disorder, Bipolar disorder, paranoia and other psychotic disorders, Obsessive-compulsive disorder, Panic disorder, Pervasive developmental disorder, Autism.

Prescription Drug Benefits

The State Health Benefits Commission and School Employees' Health Benefits Commission require that all covered employees and retirees have access to prescription drug coverage.

The Commissions reserve the right to establish dispensing limits on any medication based on Food and Drug Administration (FDA) recommendations and medical appropriateness. Prior Authorization, Drug Utilization Review, Dose Optimization, Step Therapy, and the Specialty Pharmacy Program may be employed to ensure that the medications that are reimbursed under the plan are the most clinically appropriate and cost effective. Volume restrictions currently apply to certain drugs such as sexual dysfunction drugs (Viagra, Muse, etc.).

Medicare Part D

The prescription drug benefits provided through the SHBP and SEHBP are equal to or better than the benefits provided by the standard Medicare Part D plan. Therefore, most Medicare eligible retirees and/or Medicare eligible dependents need not enroll in Medicare Part D prescription drug coverage. While some SHBP or SEHBP members who qualify for low income subsidy programs may find it beneficial to enroll in Medicare Part D, once you and/or a dependent enroll in a Medicare Part D plan, the person enrolled in Medicare Part D will lose their SHBP or SEHBP prescription drug coverage. In addition, the SHBP and SEHBP will not cover the costs of any drugs that are not covered by the Medicare Part D plan.

Employee Prescription Drug Plan

The **Employee Prescription Drug Plan** is offered to active State employees and their eligible dependents as a separate prescription drug plan. Local employers may also elect to provide the Employee Prescription Drug Plan to their employees as a separate prescription drug benefit.

The Employee Prescription Drug Plan is administered by Medco Health Solutions, Inc.

For more information about the Employee Prescription Drug Plan, copayment amounts, and specific benefits, see the *Employee Prescription Drug Plan Member Handbook* which is available at the SHBP/SEHBP home page at: ***www.state.nj.us/treasury/pensions/health-benefits.shtml***

HMO Prescription Drug Plan Administered by Medco

- **If you are employed by a county, municipality, board of education, or other local public employer that does not provide a separate prescription drug plan, or you are a retiree,** you will be enrolled in the HMO Prescription Drug Plan.
- **If you are employed and eligible for prescription drug coverage through a separate drug plan provided by your employer,** you will not be provided prescription drug coverage and any prescription drug copayments from other group plans will not be reimbursed through Aetna HMO.
- **If you a retiree enrolled in Aetna HMO or the Aetna Medicare Plan (HMO),** you will be provided prescription drug benefits under the HMO Prescription Drug Plan.

Plan Benefits (for Employees without a separate prescription drug plan and All Retirees)

The HMO Prescription Drug Plan pays, subject to any limitations specified in this section, the cost incurred for outpatient prescription drugs that are obtained from a participating pharmacy. You must present your ID card and make the copayment shown in the "Copayment Schedule" (see page 4) for each prescription at the time the prescription is dispensed.

Prescriptions from a retail pharmacy are limited to a maximum 30-day supply, with refills as authorized by your physician (but not to exceed one year from the date originally prescribed). Non-emergency prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name products where permitted by law.

Coverage is based upon Medco's formulary. The formulary includes both brand-name and generic drugs and is designed to provide access to quality, affordable outpatient prescription drug benefits. You can reduce your copayment by using a covered generic or brand-name drug that appears on the formulary. Your copayment will be highest if your physician prescribes a covered brand-name drug that does not appear on the formulary.

Mail Order Drugs

Participants in the HMO Prescription Drug Plan who must take a drug for more than 30 days may obtain up to a 90-day supply of the drug through the Medco mail order pharmacy, if authorized by their physician. The minimum quantity dispensed by a mail order pharmacy is for a 31-day supply, and the maximum quantity is for a 90-day supply. The copayment shown in the "Copayment Schedule" will apply to each mail order purchase.

Certain prescription drugs may require precertification prior to purchase (see below or contact Medco for details).

Precertification

Your pharmacy benefits include Medco's precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-authorized by Medco before they will be covered. Only your physician can request prior authorization for a drug.

The drugs requiring precertification are subject to change. Call Member Services or visit Medco's Web site for the current precertification list.

Emergency Prescriptions

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

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

- **Participating Pharmacy:** When you obtain an emergency or urgent care prescription at a participating pharmacy (including an out-of-area participating pharmacy), you must pay the copayment. Medco will not reimburse you if you submit a claim for a prescription obtained at a participating pharmacy.

Specialty Pharmacy Network Benefits

Self-injectable drugs are covered at the network level of benefits only when dispensed through **Medco's specialty pharmacy, Accredo**.

- **Specialty pharmacy services** are provided through Accredo Specialty Pharmacy which is the exclusive provider for specialty pharmaceuticals for the SHBP and SEHBP. Specialty pharmaceuticals are a class of medications that are typically produced through biotechnology, administered by injection, and/or require special patient monitoring and handling. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy. If you try to fill a specialty prescription at a retail pharmacy, the pharmacy representative will advise you to contact Accredo at 1-800-501-7260. When calling, identify yourself as a SHBP or SEHBP member. Accredo will contact your doctor and take care of the appropriate paperwork. Your medication will be shipped directly to your home, office, or doctor's office.

Covered Drugs

The HMO Prescription Drug Plan covers the following:

- Outpatient FDA-approved prescription drugs when prescribed by a provider who is licensed to prescribe federal legend drugs or medicines, subject to the terms, limitations and exclusions described in this member handbook.
- Off-label use of FDA-approved prescription drugs provided that:
  - The drug is recognized for treatment of the condition in question in one of the standard reference compendia (the-United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or
  - The safety and effectiveness of use for the condition has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.
- Diabetic supplies, as follows:
  - Diabetic needles and syringes.
  - Alcohol swabs.
  - Test strips for glucose monitoring and/or visual reading.
  - Diabetic test agents.
  - Lancets (and lancing devices).
- Contraceptives and contraceptive devices, as follows:
  - Oral contraceptives.
  - Up to 5 vials of Depo-Provera in a 365 consecutive-day period. A separate copayment applies to each vial.

- Norplant and IUDs are covered when obtained from your Primary Care Physician or participating OB/GYN. The office visit copayment will apply when the device is inserted and removed.

- Drugs prescribed to aid or enhance sexual performance, including sildenafil citrate, phentolamine, apomorphine and alprostadil in oral and topical (including but not limited to gels, creams, ointments and patches) forms. Coverage is limited to a total of no more than 4 pills/units, 6 units/vials or other forms (in unit amounts determined by Aetna to be similar in cost to oral forms) per 30-day supply. Mail order supplies are not covered.

Prescription Drug Exclusions and Limitations

Prescription Drug Exclusions

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

- Any drug that does not, by federal or state law, require a prescription order (such as an over-the-counter drug), even when a prescription is written.
- Any drug that is not medically necessary.
- Charges for the administration or injection of a prescription drug or insulin.
- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth, including (but not limited to) health and beauty aids.
- Any prescription for which the actual charge to you is less than the copayment you will pay the actual cost.
- Any prescription for which no charge is made to you.
- Insulin pumps or tubing for insulin pumps.
- Medication which is to be taken by you or administered to you, in whole or part, while you are a patient in a licensed hospital or similar facility.
- Take-home prescriptions dispensed from a hospital pharmacy upon discharge from the hospital, unless the hospital pharmacy is a participating retail pharmacy.
- Any medication that is consumed or administered at the place where it is dispensed.
- Immunization or immunological agents, including:
  - Biological sera.
  - Blood, blood plasma or other blood products administered on an outpatient basis.
  - Allergy sera and testing materials.
- Drugs used for the purpose of weight reduction, except for the treatment of obesity.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Drugs labeled "Caution – Limited by Federal Law to Investigational Use" and experimental drugs.

- Drugs prescribed for uses other than the uses approved by the FDA under the Food, Drug and Cosmetic Law and regulations.
- Medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use.
- Prescription drugs purchased prior to the effective date, or after the termination date, of coverage under this Plan.
- Replacement of lost or stolen prescriptions.
- Performance, athletic performance, or lifestyle-enhancement drugs and supplies.
- Smoking-cessation aids or drugs.
- Growth hormones, except if medically necessary.
- Test agents and devices, except diabetic test strips.
- Needles and syringes, except diabetic needles and syringes.

Prescription Drug Limitations

The following limitations apply to the prescription drug coverage:

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

Plan Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

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

- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.

  This exclusion will not apply to drugs:

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

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

- False teeth.
- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids (except as described on page 10), eyeglasses, or contact lenses or the fitting thereof.
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work.
- Implantable drugs.
- Inpatient private duty or special nursing care in any type of facility.
- Maintenance Care: Care that when provided does not substantially improve the condition. When care is provided for a condition that has reached maximum improvement and further services will not appreciably improve the condition, care will be deemed to be maintenance care and no longer eligible.
- Oral and implantable contraceptive drugs and devices not outlined under “Covered Drugs” on page 18, except when prescribed to treat certain medical conditions.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision.)
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies purchased over the counter such as syringes, incontinence pads, elastic stockings and reagent strips.

- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services, and immunizations in connection with:
  - Obtaining or continuing employment,
  - Obtaining or maintaining any license issued by a municipality, state or federal government,
  - Securing insurance coverage,
  - Travel, and
  - School admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.

  This exclusion does not apply to employer-mandated physical examinations that are prerequisite to participation in a physical fitness test that is required as a condition of continuing employment.
- Services and supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:
  - Experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,
  - Injectable drugs not considered medically necessary or used for cosmetic, performance, or enhancement purposes, or not specifically covered under this plan,
  - Drugs related to treatments not covered by the Plan, and
  - Performance-enhancing steroids.

- Specific non-standard allergy services and supplies, including (but not limited to):
  - Skin titration (rinkel method),
  - Cytotoxicity testing (Bryan's Test),
  - Treatment of non-specific candida sensitivity, and
  - Urine autoinjections.
- Speech therapy for treatment of delays in speech development *except* when deemed medically necessary for a member with autism or PDD.
- Supportive Care: Care for patients having reached the maximum therapeutic benefit in which periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. Supportive care services, even those that are considered to be medically needed are not covered.
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):
  - Primal therapy.
  - Chelation therapy, except for heavy metal poisoning
  - Rolfing.
  - Psychodrama.
  - Megavitamin therapy.
  - Purging.
  - Bioenergetic therapy.
  - Vision perception training.
  - Carbon dioxide therapy.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.

- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual.
- Treatment of occupational injuries and occupational diseases, including injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
  - Treatment performed by placing a prosthesis directly on the teeth,
  - Surgical and non-surgical medical and dental services, and
  - Diagnostic or therapeutic services related to TMJ.
- Weight reduction programs and dietary supplements.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance. For example, certain over the counter drugs (such as Prilosec) that are the equivalent of a prescription drug, but are significantly less expensive.

In Case of Medical Emergency

Guidelines

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

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

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

All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered by Aetna.

Some examples of emergencies are:

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

If you are an Aetna HMO member, we ask that you follow the guidelines listed below when you believe you may need emergency care (whether you are in or out of Aetna's service area).

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

If you are an Aetna HMO Plan (HMO) member, you are covered for emergency care worldwide.

Follow-Up Care after Emergencies

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

Note: This information applies to Aetna HMO members only. Members of the Aetna Medicare Plan (HMO) can obtain follow-up care without a referral, but should verify that the provider is participating in the Aetna Medicare Plan (HMO) network.

Urgent Care

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

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

What to Do Outside Your Aetna Service Area

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

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

Special Programs

Alternative Health Care Programs

Natural Alternatives – If you are interested in alternative therapies such as acupuncture or massage therapy, Aetna has a program to meet your needs. Aetna's Natural Alternatives program offers you special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapists and nutritional counselors.

Natural Alternatives is not available in all states.

Vitamin Advantage™ – You can save on vitamins and nutritional supplements purchased through mail order, over the phone, by fax, or over the Internet.

Natural Products – You also can save on many health-related products, including aromatherapy, foot care and natural body care products.

You may place orders by mail, telephone, fax or Internet to receive savings on health-related products offered through these programs.

To Find Out More – Call the Member Services number on your ID card, or visit Aetna on the Web at: ***www.aetna.com/statenj***. There you can find a listing of participating providers, vendors and the latest additions to the product list. Visit the Web site often! These programs are growing!

Fitness Program

Aetna offers Plan participants access to discounted fitness services provided by GlobalFit™. Plan participants can join the GlobalFit network and receive discounts on their health club membership rate. The Fitness Program offers Plan participants:

- Low or discounted membership rates at independent health clubs contracted with GlobalFit;
- Free guest passes to allow you to sample facilities before selecting a club* to join;
- Guest privileges at other participating GlobalFit health clubs,* and
- Discounts on certain home exercise equipment.

**Not available at all clubs.*

To view a list of included clubs, visit the GlobalFit Web site at: ***www.globalfit.com/fitness***. If you would like to speak with a GlobalFit representative, you can call GlobalFit at 1-800-298-7800.

Healthy Outlook Program® — Disease Management for the 21st Century

Aetna has five programs aimed at helping members and their physicians to better manage chronic disease.

Asthma Management Program (pediatric and adult)

The Asthma Management program integrates comprehensive asthma education and instruction in the use of asthma management equipment designed for home use.

Coronary Artery Disease – Secondary Prevention Program

This program focuses on prevention of secondary cardiac events associated with coronary artery disease.

Heart Failure Management Program

This program enables patients to receive certain intravenous drugs in the convenience of home and provides education to help them improve their lifestyle and reduce the risk of future hospitalizations.

Diabetes Management Program

The Diabetes Management Program combines member education with blood glucose self monitoring to help achieve better blood sugar control and lessen the chance for the complications of diabetes to develop.

Low Back Pain Disease Management Program

This program provides access to educational materials to help prevent flare-ups of low back pain.

Additional information about Aetna's Disease Management Programs can be found on Aetna's Web site at: ***www.aetna.com/products/extra/healthy_outlook.html*****.**

Member Health Education Programs

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

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

Adolescent Immunization

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

Preventive Reminders

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

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

Cancer Screening Programs

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

Breast Cancer Screening

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease. The mailer may also include information on participating mammography centers.

Cervical

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

Colorectal

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

Childhood Immunization Program

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

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

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

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

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

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

Healthy Insights Member Newsletter

Aetna periodically publishes the *Healthy Insights* newsletter. The newsletter features health-related information, education about various benefits and issues important to quality management and patient management. *Healthy Insights* is an important resource that communicates with Plan participants about a wide variety of topics.

Informed Health® Line

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

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

Backed by the Healthwise® Knowledgebase™ (a computerized database of over 1900 of the most common health problems) and an array of other online and desk references, the nurses help you understand health issues, treatment options, review specific questions to ask your provider, provide research analyses of treatments and diagnostic procedures, and explain the risks and benefits of various options. The nurses encourage patient/provider interaction by coaching you to give a clear medical history and information to providers and to ask clarifying questions.

Numbers To Know™ — Hypertension and Cholesterol Management

Aetna created *Numbers To Know*™ to promote blood pressure and cholesterol monitoring. The *Numbers To Know* mailer is sent to Plan participants who are targeted by selected diagnoses within specific age groups. The mailer includes helpful tips on blood pressure and cholesterol management; desirable goals for blood pressure and cholesterol; and a tri-fold wallet card to track blood pressure, total cholesterol, medication and dosage information.

Hypertension and high cholesterol are never "cured" but may be controlled with lifestyle changes and adherence to a treatment plan. You can help to stay "heart healthy" by monitoring your blood pressure and blood cholesterol numbers.

Numbers To Know can help encourage you to understand your illness, monitor your high blood pressure and high cholesterol and work with your physician to develop an appropriate treatment plan.

National Medical Excellence Program®

Aetna's National Medical Excellence Program® helps eligible Plan participants access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services.

The program has three components:

- National Transplantation Program, designed to help arrange care for solid organ and bone marrow transplants
- National Special Case Program, developed to coordinate arrangements for treatment of Plan participants with complex conditions at tertiary care facilities across the country when that care is not available within 100 miles of the Plan participant's home
- Out of Country Program, designed for Plan participants who need emergency inpatient medical care while temporarily traveling outside the United States.

If you need a transplant or other specialized care that cannot be provided within the service area, the NME Program will coordinate covered services and will provide the following lodging and travel expenses if you must travel more than 100 miles:

- Transportation expenses you and a companion (if applicable) incur while traveling between your home and the Program facility. Travel expenses incurred by more than one companion are not covered.
- As the NME patient, your lodging expenses incurred while traveling between your home and the National Medical Excellence facility to receive covered services;
- The lodging expenses you incur for lodging away from home to receive covered outpatient services from a NME Program provider;
- The lodging expenses incurred by a companion traveling with you from your home to a National Medical Excellence provider so you can receive covered services; and
- Your companion's lodging expenses when their presence is required to enable you to receive services from a NME Program provider on either an inpatient or outpatient basis. Only the lodging expenses incurred by **one** companion are covered per night.

Benefits for travel and lodging expenses are subject to a maximum of $10,000 per episode of care.

Travel and lodging expenses must be approved in advance by Aetna; if you do not receive approval, the expenses are **not** covered.

You become eligible for coverage of travel and lodging expenses on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest to occur of:

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

Travel and lodging expenses do not include expenses that are covered under any other part of the Plan.

The Plan covers only those services, supplies and treatments that are considered necessary for your medical condition. Treatment that is considered experimental (as determined by Aetna) is ***not*** covered by the Plan. Refer to the *Glossary* for a definition of "experimental."

Aetna Vision℠ Discount Program

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

Plan participants are also eligible to receive a discount off the usual retail charge for Lasik surgery (the laser vision corrective procedure) through providers participating in the U.S. Laser Network. Included in the discounted price is patient education, an initial screening, the Lasik procedure and follow-up care. To access LASIK surgery discounts, call 1-800-422-6600 and speak to a Lasik customer service representative.

Formerly known as the Vision One Discount Program. Vision One is a registered trademark of Cole Vision Corporation.

Women's Health Care

Aetna is focused on the unique health care needs of women. They have designed a variety of benefits and programs to promote good health throughout each distinct life stage, and are committed to educating female Plan participants about the lifelong benefits of preventive health care.

Support for Women with Breast Cancer

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

- Breast cancer information
- Second opinion options
- Information about community resources
- Benefit eligibility
- Help with accessing participating providers for:
- Wigs
- Lymphedema pumps

Call 1-888-322-8742 to reach Aetna's Breast Health Education Center.

Confidential Genetic Testing for Breast and Ovarian Cancers

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

Direct Access for OB/GYN Visits (Aetna HMO members only)

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

Infertility Case Management and Education

Infertility treatment can be an emotional experience for couples. Aetna's infertility case management unit provides Plan participants with educational materials and assistance with coordinating covered infertility care. A dedicated team of registered nurses and infertility coordinators staffs the unit.

Beginning Right℠ Maternity Program

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

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

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

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

Eligibility

Active Employee Eligibility

Eligibility for coverage is determined by the State Health Benefits Program (SHBP) or the School Employees' Health Benefits Program (SEHBP).

Enrollments, terminations, changes to coverage, etc. must be presented through your employer to either the SHBP or SEHBP. If you have any questions concerning eligibility provisions, you should call the Division of Pensions and Benefits, Office of Client Services at (609) 292-7524.

State Employees

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

Local Employees

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

Enrollment

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

Eligible Dependents

Your eligible dependents are your spouse, civil union partner, or eligible same-sex domestic partner and/or your eligible children (see definitions below).

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

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

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

Children — In compliance with the federal Patient Protection and Affordable Care Act (ACA) and effective with the plan year beginning 2011, coverage is extended for children until age 26. This includes natural children under age 26 regardless of the child's marital, student, or financial dependency status. A photocopy of the child's birth certificate that includes the covered parent's name is required for enrollment.

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

Foster children and children in a guardian-ward relationship under age 26 are also eligible. A photocopy of the child's birth certificate **and** additional supporting legal documentation are required with enrollment forms for these cases. Documents must attest to the legal guardianship by the covered employee (see page 67).

Coverage for an enrolled child ends on December 31 of the year in which he or she turns age 26 (see the "COBRA" section on page 44, "Dependent Children with Disabilities" and "Over Age Children until Age 31" below for continuation of coverage provisions).

Note: Coverage until age 26 is only available if the child is <u>not</u> eligible to enroll in other employer-based coverage (aside from coverage through the parent).

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

To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end.

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

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

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

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

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

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

Supporting Documentation Required for Enrollment of Dependents

The SHBP and SEHBP are required to ensure that only eligible employees and retirees, and their dependents, are receiving health care coverage under the program. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation in addition to the enrollment application. See page 67 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

Audit of Dependent Coverage

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

Multiple Coverage under the SHBP/SEHBP is Prohibited

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

Eligible children may only be covered by one participating subscriber.

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

Medicare Coverage While Employed

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union partner, eligible same-sex domestic partner, or dependent child(ren) to be covered by Medicare while the employee remains actively at work. **However, if you or your dependents become eligibile for Medicare due to End Stage Renal Disease (ESRD)** you and/or your dependents **must enroll** in Medicare Parts A and B even though you are actively at work. For more information, see "Medicare Coverage is Required" on page 41 of the "Retiree Eligibility" Section.

Retiree Eligibility

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

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

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

- Full-time members of the Teachers' Pension and Annuity Fund (TPAF) and school board or county college employees enrolled in the Public Employees' Retirement System (PERS) who retire with less than 25 years of service credit from an employer that participates in the SEHBP.
- Full-time members of the TPAF and school board or county college employees enrolled in the PERS who retire with 25 years or more of service credit in one or more State or locally-administered retirement systems or who retire on a disability retirement, even if their employer did not cover its employees under the SEHBP. This includes those who elect to defer retirement with 25 or more years of service credit in one or more State or locally-administered retirement systems (see "Aggregate of Pension Membership Service Credit" on page 39).
- Full-time members of the TPAF and PERS who retire from a board of education, vocational/ technical school, or special services commission; maintain participation in the health benefits plan of their former employer; and are eligible for and enrolled in Medicare Parts A and B.
- Participants in the Alternate Benefit Program (ABP) eligible for the SEHBP who retire with at least 25 years of credited ABP service or those who are on a long-term disability.

- Part-time faculty at institutions of higher education that participate in the SEHBP if enrolled in the SEHBP at the time of retirement.

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

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

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

Note: If you continue group coverage through COBRA (see page 44 for an explanation of COBRA) — or as a dependent under other group coverage through a public or private employer — until your retirement becomes effective, you will be eligible for retired coverage under the SHBP or SEHBP.

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

Aggregate of Pension Membership Service Credit

Upon retirement, a full-time State employee, board of education, or county college employee who has 25 years or more of service credit, is eligible for State-paid health benefits under the SHBP or SEHBP.

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

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

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

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage (see page 35) except for Chapter 334 domestic partners (described below) and the Medicare requirements (see page 40).

Chapter 334, P.L. 2005, provides that retirees from local entities (municipalities, counties, boards of education, and county colleges) whose employers do not participate in the in SHBP or SEHBP, but who become eligible for SHBP or SEHBP coverage at retirement (see page 38), may also enroll a registered same-sex domestic partner as a covered dependent provided that the former employer's plan includes domestic partner coverage for employees.

Multiple Coverage under the SHBP/SEHBP is Prohibited

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

Eligible children may only be covered by one participating subscriber.

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

Enrolling in Retired Group Coverage

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

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

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

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

Medicare Coverage is Required if Eligible

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

Medicare Parts A and B

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

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

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

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

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

Medicare Part D

The prescription drug benefits provided through the SHBP and SEHBP Retired Group medical plans are equal to or better than the benefits provided by the standard Medicare Part D plan. Therefore, most Medicare eligible retirees and/or their Medicare eligible dependents need not enroll in Medicare Part D prescription drug coverage. While some SHBP or SEHBP members who qualify for low income subsidy programs may find it beneficial to enroll in Medicare Part D, once you and/or a dependent enroll in a Medicare Part D plan, the person enrolled in Medicare Part D will lose their SHBP or SEHBP prescription drug coverage. In addition, the SHBP and SEHBP will not cover the costs of any drugs that are not covered by the Medicare Part D plan.

Please note: if you are enrolled in the Aetna Medicare Plan (HMO) and enroll in a Part D plan, your Aetna Medicare Plan (HMO) will be terminated. Medicare does not allow members to be enrolled in a group Medicare plan and an individual Part D Plan.

Medicare Eligibility

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

- **Medicare Eligibility by Reason of Age**

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

- **Medicare Eligibility by Reason of Disability**

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

- **Medicare Eligibility by Reasons of End Stage Renal Disease**

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

  – The individual has group health coverage of their own or through a family member (including a spouse, civil union partner, or domestic partner).

  – The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

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

  (1) An initial three-month waiting period;

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

  (3) A period where Medicare is primary.

  Three-month Waiting Period

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

  Coordination of Benefits Period

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

  When Medicare is Primary

  After the coordination of benefits period ends, **Medicare is considered the primary payer and the group health plan is secondary.** For any retiree who is enrolled in the Aetna Medicare Plan (HMO) (after becoming entitled to Medicare Part A and Part B), **the Aetna Medicare Plan (HMO) will be the primary insurance plan.**

  Dual Medicare Eligibility

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

  – If the health plan is primary because the member has active employment status, then **the group health plan continues to be primary** to 30 months from the date of dual Medicare entitlement.

  – If the health plan is secondary because the member is not actively employed, then **the health plan continues to be the secondary payer.** There is no 30-month coordination period. **.** For any members enrolled in the Aetna Medicare Plan (HMO), regardless of whether they are Medicare-eligible due to age or disability, **the Aetna Medicare Plan (HMO) will be the primary insurance plan, <u>not</u> Medicare.**

How to File a Claim If You Are Eligible for Medicare

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

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

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

New Jersey Physicians or Providers:

- You should provide the physician or provider with your identification number. This number is indicated on the *Medicare Request for Payment* (claim form) under "Other Health Insurance."
- The physician or provider will then submit the *Medicare Request for Payment* to the Medicare Part B carrier.
- After Medicare has taken action, you will receive an *Explanation of Benefits* statement from Medicare.
- If the remarks section of the *Explanation of Benefits* contains the following statement, you need not take any action: "This information has been forwarded to Aetna for their consideration in processing supplementary coverage benefits."
- If the statement shown above does not appear on the *Explanation of Benefits*, please attach a completed Aetna claim form, to a copy of the itemized bill from your physician or provider along with a copy of the Medicare *Explanation of Benefits,* and submit it to Aetna using the address on the back of your ID card.

Out-Of-State Physicians or Providers:

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

COBRA Coverage

Continuing Coverage When It Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods (see "Duration of COBRA Coverage" on page 45), and the member must pay the full cost of the coverage plus an administrative fee.

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

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

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

COBRA Events

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

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

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

Cost of COBRA Coverage

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

Duration of COBRA Coverage

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

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

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

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

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

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

Employee Responsibilities Under COBRA

The law requires that you and your dependents:

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

Failure to Elect COBRA Coverage

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

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause.)
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not continue coverage under COBRA for the maximum time available to you.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you.

Termination of COBRA Coverage

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

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

Special Plan Provisions of the Health Benefits Program

Automobile-Related Injuries

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

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

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

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

- The remaining uncovered allowable expenses after the PIP policy has provided coverage. The expenses will be subject to medical appropriateness and any other provisions of your Plan, after application of any deductibles and coinsurance; or
- The actual benefits that would have been payable had your Plan been primary to your PIP policy.

If you are enrolled in several health plans regardless of whether you have selected PIP as your primary or secondary coverage, the plans will coordinate benefits as dictated by each plan's coordination of benefits terms and conditions. You should consult the coordination of benefits provisions in your various plans’ handbooks and your PIP policy to assist you in making this decision.

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

Work-Related Injury or Disease

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

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

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

Health Insurance Portability and Accountability Act

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

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. Credit under this plan includes any prior group plan that was in effect 90 days prior to the individual's effective date under the new plan. A *Certification of Coverage* form, which verifies your group health plan enrollment and termination dates, is available through your payroll or human resources office, should you terminate your coverage.

HIPAA Privacy

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

Medical Plan Extension of Benefits

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

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

Termination for Cause

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

- **Untenable relationship**: After reasonable efforts, Aetna and/or the Plan's participating providers are unable to establish and maintain a satisfactory provider-patient relationship with the member, or the member repeatedly acts in a manner which is verbally or physically abusive.
- **Failure to make copayments**: The member fails to make required copayments or any other payment which he or she is required to pay.
- **Misuse of identification card**: The member permits any person to use his or her Aetna identification card.

- **Furnishing incorrect or incomplete information**: The member willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in or obtaining benefits from the Plan.
- **Non-compliance with your physician's plan of treatment:** You have the right to refuse any drugs, treatment or other procedure offered to you by a participating provider, and to be informed by your physician of the medical consequences of your refusal of any drugs, treatment or procedure. Aetna and your Primary Care Physician will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended plan of treatment, the Plan will not be responsible for the costs of further treatment for that condition, and you will be so notified. You may use the grievance and appeal process to have your case reviewed (see page 55).
- **Misconduct:** The member abuses the system, including, but not limited to, theft, fraud, damage to the property of a participating provider or forgery of drug prescriptions.

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

Health Care Fraud

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

Member Services

Member Services Department

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

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

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

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

Internet Access

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

When you visit the Member Services site, you can:

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

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

InteliHealth®

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

Clinical Policy Bulletins

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

Aetna Navigator®

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

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

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

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

Coordination of Benefits

When Coordination of Benefits Applies

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

Allowable Expense

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

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

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

Plans That May Coordinate

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

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;

- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- **Medicare** or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

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

This Plan is any part of the policy that provides benefits for health care expenses.

Which Plan Pays First (Aetna HMO members only – *Medicare members see note on page 53*)

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

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

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

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

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

   - The parents are married or living together whether or not married;
   - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

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

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

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

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

3. **Active Employee or Retired or Laid off Employee.** The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the **primary plan**. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the **secondary plan**. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules listed above determine the order of benefits.
4. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules listed above determine the order of benefits.
5. **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, and subscriber longer is primary.
6. **If the preceding rules do not determine the primary plan,** the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, **This Plan will <u>not</u> pay more than it would have paid had it been primary.**

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

How Coordination of Benefits Works

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

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

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

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

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

If You Receive a Bill

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

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

Grievances and Appeals

The Plan has procedures for you to follow if you are dissatisfied with a decision that Aetna has made or with the operation of the Plan. The process depends on the type of complaint you have. There are two categories of complaints:

- Quality of care or operational issues; and
- Adverse benefit determinations.

Complaints about quality of care or operational issues are called **grievances**. Complaints about adverse benefit determinations are called **appeals**.

Grievances

Quality of care or operational issues arise if you are dissatisfied with the service received from Aetna or want to complain about a participating provider. To make a complaint about a quality of care or operational issue (called a grievance), call or write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written decision within 30 calendar days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will specify what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

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

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

Aetna will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made in writing within 180 days from the receipt of the notice. However, appeals of adverse benefit determinations involving urgent care may be made orally.

The Plan provides for two levels of appeal, plus an option to seek external review of the adverse benefit determination. You must complete the two levels of appeal before bringing a lawsuit against the plan. If you are dissatisfied with the outcome of your level one appeal and wish to file a level two appeal, your appeal must be filed no later than 60 days following receipt of the level one notice of adverse benefit determination. The chart on the next page summarizes some information about how appeals are handled for different types of claims.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

Depending on the type of appeal, you and/or an authorized representative may attend the Level Two appeal hearing and question the representative of the Plan and any other witnesses, and present your case. The hearing will be informal. You may bring your physician or other experts to testify. The Plan also has the right to present witnesses.

If the Plan's appeals process upholds the original adverse benefit determination, you may have the right to pursue a Health Benefits Commission review of your claim. See “Health Benefits Commission Appeal” on page 57 for more information.

Benefit Appeal Time Frames

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

Extensions of Time Frames

The time periods described in the chart may be extended.

For urgent care claims: If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided.

For non-urgent pre-service and post-service claims: The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

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

How to File an Appeal

You or your authorized representative may appeal and request that your health plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or medical nature. Administrative appeals might question eligibility or plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of medical need, appropriateness of treatment, or experimental and/or investigational procedures.

The following information must be given at the time of each inquiry.

- Name(s) and address(es) of patient and employee;
- Employee's identification number;
- Date(s) of service(s);
- Provider's name and identification number;
- The specific remedy being sought; and
- The reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim that was not given when the claim was first submitted, be sure to include it.

Health Benefit Commission Appeal

If dissatisfied with a final health plan decision on a medical appeal, only the member or the member's legal representative (this does not include the provider of service) may appeal, in writing, to the State Health Benefits Commission or the School Employees' Health Benefits Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf. Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

Appeals Coordinator
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

Notification of all Commission decisions will be made in writing to the member. If the Commission approves the member's appeal, the decision is binding upon the health plan. If the Commission denies the member's appeal, the member will be informed of further steps he or she may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request, within 45 days in writing to the Commission, that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so the case will be forwarded to the Office of Administrative Law.

An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals will be made to the Superior Court of New Jersey, Appellate Division.

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

Claim Fiduciary

Your employer has complete discretionary authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, your employer 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 Plan.

Your employer has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. Your employer may not abuse its discretionary authority by acting arbitrarily and capriciously. Your employer is responsible for making reports and disclosures required by applicable laws and regulations.

Subrogation and Right of Recovery Provision

Definitions

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

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

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

Subrogation

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

Reimbursement

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

Constructive Trust

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

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim

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

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses.

The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

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

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Your Rights and Responsibilities

As a Plan participant, you have a right to:

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

As a Plan participant, you have the responsibility to:

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

Patient Self-Determination Act (Advance Directives)

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

What Is an Advance Directive?

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

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

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

What Is a Living Will?

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

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

What Is a Durable Power of Attorney for Health Care?

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

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

Who Decides About My Treatment?

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

How Do I Know What I Want?

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

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

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

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

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

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

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

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

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

Do I Have to Execute an Advance Directive?

No. It is entirely up to you.

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

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

Can I Change My Mind After Writing an Advance Directive?

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

What Is the Plan's Policy Regarding Advance Directives?

We share your interest in preventive care and maintaining good health. Eventually, however, every family may face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important in the future and urge you to discuss these topics with your Primary Care Physician, family, friends, and other trusted, interested people.

You are not required to execute an Advance Directive. **If you choose to complete an Advance Directive, it is your responsibility to provide a copy to your physician and to take a copy with you when you check into a hospital or other health facility so that it can be kept with your medical records**.

How Can I Get More Information About Advance Directives?

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

Federal Notices

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

The Newborns' and Mothers' Health Protection Act

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

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

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

The Women's Health and Cancer Rights Act

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

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

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

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

Grandfathered Health Plan Notice

Plan Sponsor Name: The State of New Jersey

The State of New Jersey believes your plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your employer or Aetna member services using the phone number on your member ID card.

If your plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or *www.dol.gov/ebsa/healthreform* This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. If your plan is a nonfederal governmental plan, you may also contact the U.S. Department of Health and Human Services at *www.healthreform.gov*

Plan Information

Amendment or Termination of the Plan

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

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

Plan Documents

This plan description covers the major features of the Plans administered by Aetna Life Insurance Company, effective April 1, 2008. The plan description has been designed to provide a clear and understandable summary of the Plan.

Provider Termination

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

Required Documentation for Dependent Eligibility and Enrollment

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

Specific required documents are detailed in the chart on page 68.

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

Required Documentation for Dependent Eligibility and Enrollment

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

Continued on next page

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

Required Documentation for Dependent Eligibility and Enrollment

Dependent	Eligibility Definition	Required Documentation
Children	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation. Coverage until age 26 is only available if an adult child is <u>not</u> eligible to enroll in other employer-based coverage (aside from coverage through the parent).	**Natural or Adopted Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. Step Child – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.
Dependent Children with Disabilities	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. See "Dependent Children with Disabilities" on page 36 for additional information. You will be contacted periodically to verify that the child remains eligible for continued coverage.	Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* *(Form 1040)* that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. **Please note** that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
Continued Coverage for Over Age Children	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. See "Over Age Children until Age 31" on page 37 for additional information.	Documentation for the appropriate "Child" type (as noted above), **and** a photocopy of the front page of the child's most recently filed federal tax return* (Form 1040), and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

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

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hospice Care – A program of care that is:

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

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

(1) It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals and Medicare approved.

(2) It (a) is legally operated, (b) is supervised by a staff of doctors, (c) has 24-hour-a-day nursing service by registered graduate nurses, and (d) mainly provides general inpatient medical care and treatment of sick and injured persons by the use of the medical, diagnostic, and major surgical facilities in it.

(3) It is licensed as an ambulatory or separate surgical center. The center must mainly provide outpatient surgical care and treatment.

(4) It is an institution for the treatment of alcoholism not meeting all the tests of (1) or (2) but which is:

- A licensed hospital; or
- A licensed detoxification facility; or
- A residential treatment facility which is approved by a state under a program that meets standards of care equivalent to those of the Joint Commission on Accreditation of Hospitals.

(5) It is a birth center that is licensed, certified, or approved by a department of health or other regulatory authority in the state where it operates or meets **all** of the following tests:

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

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

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

Infertility – Means you are not able to:

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

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

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

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

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

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

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

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

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

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

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

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

Member – An employee or covered dependent enrolled in the Aetna HMO.

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

- Psychosis;
- Affective disorders;

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

NME Patient – A person who:

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

Outpatient – This is:

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

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

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

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

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

Plan Participant – A member enrolled in the Aetna HMO.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine & Dentistry of NJ
- Thomas A. Edison State College
- William Paterson University
- Ramapo State College
- Rowan University
- College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- New Jersey State Library
- New Jersey State legislature and legislative offices
- New Jersey Building Authority
- New Jersey Commerce and Economic Growth Commission
- Waterfront Commission of New York Harbor
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program.

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

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

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

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

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

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