Consultant Summary Plan Description
Effective January 1, 2012

**Experis Medical Plan**

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General Overview

Experis has retained the services of Aetna to provide claims administration services for the Experis Choice Plus and Secure Medical Plans, the medical plan options offered to Consultants.

The Plans do not limit your right to choose your own medical care. If a medical service is not a covered benefit, or is subject to a limitation or exclusion, you still have the right to receive the medical service or supply at your own expense. Also, if a provider is not a participating provider, you still have the right to utilize that provider at the Plans’ reduced benefit level, but you are responsible for a larger percentage of the total medical expense.

Your medical coverage will pay for a variety of hospital and other medical charges incurred because of sickness or accidental injury. The medical plan options available include:

• The Experis Choice Plus Medical Plan with Health Savings Account (HSA)
• The Secure Medical Plan

Aetna processes your medical claims and answers your medical claim questions for the Experis Choice Plus and Secure Medical Plans.

For general benefit information, including enrollment, eligibility and coverage changes, please consult the Administrative Overview section.

Schedule of Benefits

This schedule of Benefits provides a brief overview of Plan benefits and is not a complete description. Refer to the descriptions following the Schedule of Benefits for a detailed description of your Plan benefits.

All health benefits shown on the Schedule of Benefits are subject to the annual maximums, individual and family deductibles, co-pays, coinsurance rates, and out-of-pocket maximums, and are subject to all provisions of the Plan including medical necessity.

Note: Certain covered services require pre-certification before benefits will be considered for payment. Refer to the Services Requiring Pre-certification section of this document for a description of these services and certification procedures.
Medical Plan Overview

<table>
<thead>
<tr>
<th></th>
<th>Choice Plus Plan</th>
<th>Secure Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Annual Deductible:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$1,300</td>
<td>$2,600</td>
</tr>
<tr>
<td>Employee plus child(ren)</td>
<td>$2,600</td>
<td>$5,200</td>
</tr>
<tr>
<td>Employee plus spouse/DP</td>
<td>$2,600</td>
<td>$5,200</td>
</tr>
<tr>
<td>Employee plus family</td>
<td>$3,900</td>
<td>$7,800</td>
</tr>
<tr>
<td><strong>Coinsurance (What Plan Pays)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$8,000</td>
<td>$16,000</td>
</tr>
<tr>
<td>Employee + Spouse/DP</td>
<td>$8,000</td>
<td>$16,000</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$9,300</td>
<td>$18,600</td>
</tr>
<tr>
<td><strong>Health Savings Account</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

When the amount of combined covered expenses paid by you and/or all your covered dependents satisfy the out-of-pocket maximums, including the deductible, the Plan will pay 100% of covered expenses for the remainder of the calendar year, unless specifically indicated, subject to any calendar year maximums of the Plan.

If you and your covered dependents use a combination of in-network and out-of-network providers, the out-of-network deductible will reduce the in-network deductible, and the in-network deductible will reduce the out-of-network deductible.
# Choice Plus Medical Plan Summary of Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Injections, Vials &amp; Testing</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Chemotherapy:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital/Facility Charge</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Chiropractic Care (Limited to a maximum of 24 visits per calendar year):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exams</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Manipulations, Therapy and Routine Maintenance Care</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>X-ray and Lab</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% after deductible and may be subject to precertification requirements</td>
<td>60% after deductible and may be subject to precertification requirements</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Free Standing (Outpatient) Surgical Facility</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>In-network and out-of-network covered expenses aggregate to a maximum of 100 days per calendar year.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care (Inpatient and Outpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network Provider</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Infertility Treatment (limited to diagnostic care only)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td></td>
<td>Pre-certification is required.</td>
<td>Pre-certification is required.</td>
</tr>
<tr>
<td>Lab &amp; X-ray (other than part of a routine exam)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Mental Disorder, Chemical Dependence and Alcoholism (inpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td></td>
<td>Pre-certification is required.</td>
<td>Pre-certification is required.</td>
</tr>
<tr>
<td>Mental Disorder, chemical Dependence and Alcoholism (outpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td></td>
<td>Pre-certification is required.</td>
<td>Pre-certification is required.</td>
</tr>
<tr>
<td>Newborn Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Baby (Hospital)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Sick Baby</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>80% after deductible, unless preventive in nature, then 100%</td>
<td>60% after deductible, unless preventive in nature. Preventive visits are not covered.</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Specific oral surgical procedures covered.</td>
<td>Specific oral surgical procedures covered.</td>
</tr>
<tr>
<td></td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Precertification required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Travel and lodging expenses covered up to $10,000</td>
<td></td>
</tr>
<tr>
<td>Other Covered Expenses</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network Provider</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>80% after deductible.</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td></td>
<td>For surgical physician assistant charges, 20% of primary surgeon’s allowed charge is covered</td>
<td>For surgical physician assistant charges, 20% of primary surgeon’s allowed charge is covered</td>
</tr>
<tr>
<td>Pregnancy Benefits</td>
<td>Payable the same as any other sickness</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td></td>
<td>Precertification may be required</td>
<td>Precertification may be required</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital/Facility Charge</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital/Facility Charge</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Routine Adult Care (subject to recommended ages and frequencies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Lab and X-rays</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Immunizations</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Pap Smears and Prostate Antigen Testing</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Cancer Screenings (Example: colonoscopy, sigmoidoscopy, proctosigmoidoscopy)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Child Care Exams (Through Age 19)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine X-rays, Lab and Immunizations</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td></td>
<td>In-network and out-of-network covered expenses aggregate to a maximum of 90 days of confinement per calendar year.</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network Provider</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Therapies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Hearing, Physical, Occupational, and Speech Therapy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician/Therapist Office Visit</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital/Facility Charge</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>In-network and out-of-network covered expenses aggregate to a maximum of 30 visits per therapy type per calendar year for physical, occupational and speech therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Vision Therapy</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Choice Plus Medical Plan Prescription Drug Coverage

#### Preventive Drugs

<table>
<thead>
<tr>
<th>Prescription Deductible</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Prescriptions (up to a 30 day supply):</td>
<td></td>
</tr>
<tr>
<td>• Generic</td>
<td>• 90%, $5 maximum copay</td>
</tr>
<tr>
<td>• Brand</td>
<td>• 80%, $50 maximum copay</td>
</tr>
<tr>
<td>• Brand Non-Preferred</td>
<td>• 60%, $100 maximum copay</td>
</tr>
<tr>
<td>Mail Order Prescriptions (up to a 90 day supply):</td>
<td></td>
</tr>
<tr>
<td>• Generic</td>
<td>• 90%, $15 maximum copay</td>
</tr>
<tr>
<td>• Brand</td>
<td>• 80%, $150 maximum copay</td>
</tr>
<tr>
<td>• Brand Non-Preferred</td>
<td>• 70%, $300 maximum copay</td>
</tr>
</tbody>
</table>

#### Non-Preventive Drugs

<table>
<thead>
<tr>
<th>Prescription Deductible</th>
<th>Integrated with Medical Plan (so your medical deductible applies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Out-of-Pocket Maximum</td>
<td>Integrated with Medical Plan (so your medical out-of-pocket maximum applies)</td>
</tr>
<tr>
<td>Retail Prescriptions (up to a 30 day supply):</td>
<td></td>
</tr>
<tr>
<td>• Generic</td>
<td>• 80% after deductible</td>
</tr>
<tr>
<td>• Brand</td>
<td>• 80% after deductible</td>
</tr>
<tr>
<td>• Brand Non-Preferred</td>
<td>• 80% after deductible</td>
</tr>
<tr>
<td>Mail Order Prescriptions (up to a 90 day supply):</td>
<td></td>
</tr>
<tr>
<td>• Generic</td>
<td>• 80% after deductible</td>
</tr>
<tr>
<td>• Brand</td>
<td>• 80% after deductible</td>
</tr>
<tr>
<td>• Brand Non-Preferred</td>
<td>• 80% after deductible</td>
</tr>
</tbody>
</table>

Prescription drug coverage is a component of the Choice Plus Medical Plan and is administered through the medical plan administrator, Aetna.

The prescription drug program has a mandatory generic substitution provision. This means that the pharmacy will automatically dispense the generic version of a medication if one exists, unless your physician specifies “Dispense as Written” on each prescription. You should discuss using generic drugs with your physician whenever possible. By law, they must contain the same active ingredients as brand name drugs, yet they usually cost significantly less. If you receive a brand name drug when a generic equivalent is available, you will be charged the brand coinsurance (listed above) plus the cost difference between the generic and brand drug. This is true even if the physician writes, “dispense as written” on the prescription.
Aetna’s drug list (formulary) shows which medications are considered preventive and medications that are generic, brand and non-preferred. This list will help you to determine whether the medical plan deductible will apply and also your prescription coinsurance. It is also a resource that your doctor can refer to when considering your prescription choices. To find Aetna’s prescription drug list, visit www.aetna.com.

Health Savings Account (HSA)

What is an HSA?
When you enroll in the Experis Choice Plus Medical Plan, you have the option of opening and contributing to a Health Savings Account (HSA). An HSA is a savings vehicle that enables you to pay for qualified health care expenses and save for future health care expenses on a tax-free basis. With a Health Savings Account, you own the account and can access it even if you change medical plans, change your job, or retire. The funds in your HSA rollover year after year (no use it or lose it rule) and earn interest tax-free.

Although you can withdraw funds from your HSA for qualified medical expenses at any time, you must be enrolled in a qualified high deductible medical plan to contribute to your HSA (see the section “who can have an HSA?”).

How is my HSA Funded?
When you enroll through the Experis Benefit Service Center, you have the option of enrolling in the Aetna HealthFund HSA. You choose how much you want to contribute each year and pre-tax deductions will be taken from your paycheck and deposited into your HSA account. You can contribute up to the annual maximum determined by the IRS. For 2012 the limits are: $3,100 individual coverage and $6,250 for all other tiers. If you are over age 55 and not enrolled in Medicare, you may be eligible to contribute an additional “catch-up” amount to your HSA. Consult your tax advisor for information about these contribution limits. The catch-up contributions are not subject to an excise tax. You can also choose to fund your HSA directly, not through your paycheck, post-tax. If you contribute to your HSA post-tax, you can deduct your contribution from your federal tax return. Consult your tax advisor on deducting your contribution from your taxes.

Contributions in excess of the maximum annual contribution limit are subject to an excise tax. It is your responsibility to determine whether contributions to your HSA account have exceeded your maximum annual contribution limit. If contributions to your HSA exceed the maximum annual contribution limit, you must notify Aetna of the excess amount.

Money in your HSA earns interest tax-free. If you have a balance of over $2,000 in your HSA, you can invest in Mutual Funds through JP Morgan Chase. Contact Aetna for additional information on the investment account fees and fund choices through JP Morgan Chase.

You are not eligible to roll HRA funds into your Aetna HealthFund HSA.
Who can have an HSA?
Anyone who meets the following criteria can open and contribute to an HSA:

1. Has coverage under a qualified high deductible health plan (such as the Manpower HSA Plan);
2. Have no other first-dollar medical coverage (other types of insurance like specific injury insurance or accident, disability, dental care, vision care or long-term care insurance are permitted);
3. Are not enrolled in Medicare;
4. Cannot be claimed as a dependent on another person’s tax return (does not apply to spouses)

If you meet the above criteria, you can open an HSA with any custodian (bank, insurance company). You do not have to open an HSA through the Experis plan.

Using your HSA
You can use the money in the account to pay for any “qualified medical expense” permitted under federal tax law. This includes most medical care and services, dental and vision care. For more information on what is a “qualified medical expense,” go to the US Treasury website.

If you enroll in an HSA with Aetna, you have three ways to access funds in your account:

1. Use your debit card;
2. Submit a claim; or
3. Enroll in Auto debit

Debit Card: Aetna will send you a debit card, which you can use to pay for qualified medical expenses wherever a VISA card is accepted.

Submit a claim: You can get claim forms from www.aetna.com and submit the claim and documentation to Aetna for reimbursement.

Auto Debit: Aetna will withdraw funds from your HSA account to pay for qualified out-of-pocket expenses, up to your available balance. Aetna pays your doctor directly with those funds. Your doctor then bills you for any portion that was not paid by your HSA. Auto Debit is based on claims processed through your medical plan. Your Auto Debit enrollment will continue year after year until you choose to cancel your participation in Auto Debit or you leave the high deductible health plan.

NOTE: with Auto Debit, you do not have the choice of which out-of-pocket expenses are paid from the HSA Account. If you want to save money in your HSA for future use, you may not wish to enroll in Auto Debit.
Auto Debit will not apply in the following situations:

1. Expenses outside of your medical plan (example: dental expenses) money will not automatically be taken from your HSA.
2. If you are covering a domestic partner who is not a tax-qualified dependent under the health plan.
3. Pharmacy claims (you can use your debit card)
4. Expenses that fall outside of the effective dates of your HSA
5. Claims that are submitted for expenses that are covered under another health plan
6. Claims submitted after you have already paid the doctor for the service
7. Spousal HSA accounts
8. Claims in which payment is set to be made directly to you instead of the doctor

What happens to my HSA when I die?
If your spouse becomes the owner of the account, your spouse can use it as if it were their own HSA. If you are not married, the account will no longer be treated as an HSA upon your death. The account will pass your beneficiary or become part of your estate (and be subject to any applicable taxes).
## Secure Medical Plan Summary of Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Injections, Vials &amp; Testing</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>$45 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital/Facility</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Chiropractic Care (Limited to a maximum of 24 visits per calendar year)</td>
<td>$45 copay (30 visit maximum)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>True Emergency: $200 copay per visit (copay waived if admitted)</td>
<td>True Emergency: $200 copay per visit (copay waived if admitted)</td>
</tr>
<tr>
<td></td>
<td>Non-Emergency: Not Covered</td>
<td>Non-Emergency: Not Covered</td>
</tr>
<tr>
<td>Free Standing (Outpatient) Surgical Facility</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>In-network and out-of-network covered expenses aggregate to a maximum of 120 days per calendar year.</td>
<td></td>
</tr>
<tr>
<td>Hospice Care (Inpatient and Outpatient)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Infertility Treatment (limited to diagnostic care only)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
## Secure Medical Plan – cont.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Pre-certification is required</td>
<td>Pre-certification is required</td>
</tr>
<tr>
<td>Lab &amp; X-ray (other than part of a routine exam)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Mental Disorder, Chemical Dependence and Alcoholism (inpatient)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Pre-certification is required</td>
<td>Pre-certification is required</td>
</tr>
<tr>
<td>Mental Disorder, Chemical Dependence and Alcoholism (inpatient)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Pre-certification is required</td>
<td>Pre-certification is required</td>
</tr>
<tr>
<td>Newborn Benefits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Baby (Hospital)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Sick Baby (Hospital)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physician</td>
<td>$35 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialty care physician</td>
<td>$45 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Specific oral surgical procedures covered.</td>
<td>Specific oral surgical procedures covered.</td>
</tr>
<tr>
<td></td>
<td>Same as any other sickness.</td>
<td>Same as any other sickness.</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Travel and lodging expenses covered up to $10,000</td>
<td></td>
</tr>
<tr>
<td>Other Covered Expenses</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>70% after deductible.</td>
<td>50% after deductible.</td>
</tr>
<tr>
<td></td>
<td>For surgical physician assistant</td>
<td>For surgical physician assistant</td>
</tr>
<tr>
<td></td>
<td>charges, 20% of primary surgeon’s</td>
<td>charges, 20% of primary surgeon’s</td>
</tr>
<tr>
<td></td>
<td>allowed charge is covered.</td>
<td>allowed charge is covered</td>
</tr>
<tr>
<td>Pregnancy Benefits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit: pre/post natal</td>
<td>$45 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>In-Hospital delivery service</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Newborn nursery service</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>70% after deductible;</td>
<td>50% after deductible;</td>
</tr>
<tr>
<td></td>
<td>Pre-certification required</td>
<td>Pre-certification required</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>$45 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital/Facility Charge</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>$45 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital/Facility Charge</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Routine Adult Care (subject to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>recommended ages and frequencies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>100%, no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Lab and X-rays</td>
<td>100%, no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Immunizations</td>
<td>100%, no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>100%, no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Pap Smears and Prostate Antigen</td>
<td>100%, no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Cancer Screenings</td>
<td>100%, no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(Example: colonoscopy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network Provider</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td><strong>Routine Child Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Through Age 19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exams</td>
<td>100%, no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine X-rays, Lab and Immunizations</td>
<td>100%, no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

In-network and out-of-network covered expenses aggregate to a maximum of 60 days of confinement per calendar year.

| Surgeon Assistant           | 20% of the primary surgeon’s allowable fee, 70% after deductible | 20% of the primary surgeon’s allowable fee, 50% after deductible |

| Therapies                   |                              |                         |
| (Hearing, Physical, Occupational, and Speech Therapy) | | |
| • Physician/Therapist Office Visit | 70% after deductible          | 50% after deductible    |
| • Outpatient Hospital/Facility Charge | 70% after deductible          | 50% after deductible    |

In-network and out-of-network covered expenses aggregate to a maximum of 30 visits per therapy type per calendar year for physical, occupational and speech therapy.

| Urgent Care Center          | $45 copay                     | 50% after deductible    |
| Vision Therapy              | Not covered                   | Not covered             |
## Secure Medical Plan Prescription Drug Coverage

### Preventive Drugs

<table>
<thead>
<tr>
<th>Prescription</th>
<th>Description</th>
<th>Retail Prescriptions (up to a 30 day supply):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Generic $10 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brand 20% ($20 min, $40 max)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brand Non-Preferred 40% ($50 min, $100 max)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mail Order Prescriptions (up to a 90 day supply):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Generic $30 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brand 20% ($60 min, $120 max)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brand Non-Preferred 40% ($150 min, $300 max)</td>
</tr>
</tbody>
</table>

### Non-Preventive Drugs

<table>
<thead>
<tr>
<th>Prescription</th>
<th>Description</th>
<th>Retail Prescriptions (up to a 30 day supply):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Generic $10 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brand 20% ($20 min, $40 max)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brand Non-Preferred 40% ($50 min, $100 max)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mail Order Prescriptions (up to a 90 day supply):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Generic $30 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brand 20% ($60 min, $120 max)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brand Non-Preferred 40% ($150 min, $300 max)</td>
</tr>
</tbody>
</table>

Prescription drug coverage is a component of the Secure Medical Plan and is administered through the medical plan administrator, Aetna.

Aetna’s drug list (formulary) shows which medications are considered preventive as well as medications that are generic, brand and non-preferred. This list will help you to determine whether the prescription drug deductible will apply and also your prescription copay/coinsurance. To find Aetna’s prescription drug list, visit www.aetna.com.
How Your Medical Coverage Works

Deductibles
The deductible is the amount you pay each year before the Plans start paying a portion of eligible medical charges for certain services – only covered expenses will count toward meeting the deductible. A new deductible must be met each calendar year. The individual and family deductible amounts are shown on the Plan Overview included in this summary.

Choice Plus Medical Plan Deductible
You must meet your deductible amount before the Plan begins paying your eligible medical charges. If you elect individual coverage then you must meet the individual deductible amount before the Plan begins paying for your eligible medical charges. If you elect family coverage, any combination of covered family members can help meet the family deductible. For family coverage, the deductible can be met by one individual or a combination of individuals covered under the same plan. Once the family deductible is satisfied, the plan begins paying for the family’s eligible medical charges.

Here are two examples of how a family’s in-network claims apply to the deductible:

Example 1: Member 1 has a covered claim for $5,000
- $3,900 is applied to the deductible
- Family pays deductible = $3,900
- Plan pays 80% coinsurance (remaining $1,100) = $880
- Family pays 20% coinsurance = $220
- Deductible is met for the plan year

Example 2:
Member 1 has a covered claim for $1,000
Member 2 has a covered claim for $2,000
Member 3 has a covered claim for $800
Member 4 has a covered claim for $500
- $3,900 would be applied to the deductible
- Family pays deductible = $3,900
- Plan pays 80% coinsurance (remaining $400) = $320
- Family pays 20% coinsurance = $80

For the Choice Plus Medical Plan, if you and covered dependents use a combination of participating and non-participating providers, the participating and non-participating deductible amounts will reduce each other.
Secure Medical Plan Deductible
Each individual enrolled in the Secure Medical Plan must meet his or her deductible amount before the Plan begins paying for that person’s eligible medical charges. If you have family coverage, any combination of covered family members can help meet the maximum family deductible, up to each person’s individual deductible amount. Once the family deductible is satisfied, no further individual deductibles need to be met for that calendar year.

As an example, the Secure Medical Plan has a $3,500 individual in-network deductible and a $7,000 family in-network deductible. If a family of five is utilizing services that are subject to a deductible, any one covered person would only need to pay $3,500 prior to the Plan making payment for that individual. A total of $7,000 for the entire family (maximum of $3,500 per person) would have to be paid prior to the Plan making payment for all covered members of the family. The Plan would then start making payment on all covered members of the family.

Co-Payment (co-pay)
A co-pay is the amount you pay to the provider each time certain services are received.

Co-pays do not apply towards satisfaction of the individual or family deductible, or out-of-pocket maximums. Co-pay amounts are shown on the Schedule of Benefits.

Coinsurance
Coinsurance is the amount of money you pay toward eligible charges. You and the Plan each pay a percentage of the covered expenses.

For example, after you have met the deductible, the Choice Plus Medical Plan pays 80% of the charges remaining, and you pay the remaining 20% (if you go to an in-network provider) for inpatient hospital services. With the Secure Medical Plan, after you have met the deductible, the Plan pays 70% of usual and customary charges remaining, and you pay the remaining 30% (if you go to an in-network provider).

Out-of-Pocket Maximums
Annual out-of-pocket maximums are the amount of money you pay in total (deductible and coinsurance) before a Plan makes payment at 100% of usual and customary charges for the remainder of the plan year. After an individual or family has met its respective out-of-pocket maximums during a calendar year (plan year), the Plan will pay the remaining covered expenses incurred during the rest of that year, subject to:

- The maximum fee schedule;
- Negotiated rates agreed to; or
- The usual and customary amount.

Annual out-of-pocket maximums are shown on the Plan overview.
Items not included in the Choice Plus Medical Plan annual out-of-pocket maximum are:

- Co-pays;
- Penalties;
- Expenses for excluded services;
- Any charges above the limits that are specified elsewhere in the Plan.

Items not included in the Secure Plan annual out-of-pocket maximum are:

- Co-pays;
- Penalties;
- Expenses for excluded services;
- Any charges above the limits that are specified elsewhere in the Plan; and
- Co-pays and coinsurance amounts for prescription products.

**Lifetime Maximum**

Lifetime maximum means the maximum amount of benefits available while you are covered under the Plan. Under no circumstances does lifetime mean during the lifetime of the covered person. The Experis medical plans do not include a lifetime maximum.
## Services Requiring Pre-Certification

To obtain maximum benefits, you must call Aetna before you receive services for the following non-emergency services:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Medical/Surgical Confinements</td>
<td>Aetna must be notified at least 7 days prior to admission. If admitted following a visit to the emergency room, you must contact Aetna within 48 hours following admission.</td>
</tr>
<tr>
<td>Bariatric Surgery for Morbid Obesity</td>
<td>Aetna must be notified prior to services being rendered.</td>
</tr>
<tr>
<td>Home Health Care/Infusion or Home Hospice</td>
<td>Aetna must be notified prior to services being rendered.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Aetna must be notified prior to services being rendered.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Aetna must be notified for the following four categories of DME/Prosthetics:</td>
</tr>
<tr>
<td></td>
<td>- Electric or motorized wheelchairs and scooters</td>
</tr>
<tr>
<td></td>
<td>- Clinitron and electric beds</td>
</tr>
<tr>
<td></td>
<td>- Limb prosthetics</td>
</tr>
<tr>
<td></td>
<td>- Customized braces</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>Aetna must be notified prior to services being rendered.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Requirements</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cochlear Implants</td>
<td>Aetna must be notified prior to services being rendered.</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Aetna must be notified prior to service being rendered.</td>
</tr>
<tr>
<td>Reconstructive or other procedures</td>
<td>Aetna must be notified prior to services being rendered.</td>
</tr>
<tr>
<td>that may be considered cosmetic</td>
<td></td>
</tr>
<tr>
<td>Uvulopalatopharyngoplasty, including</td>
<td>Aetna must be notified prior to services being rendered.</td>
</tr>
<tr>
<td>laser-assisted procedures</td>
<td></td>
</tr>
<tr>
<td>Orthognathic surgery procedures,</td>
<td>Aetna must be notified prior to services being rendered.</td>
</tr>
<tr>
<td>bone grafts, osteotomies and surgical</td>
<td></td>
</tr>
<tr>
<td>management of the temporomandibular</td>
<td></td>
</tr>
<tr>
<td>joint</td>
<td></td>
</tr>
<tr>
<td>Non-emergency ambulance including</td>
<td>Aetna must be notified prior to services being rendered.</td>
</tr>
<tr>
<td>inter-facility transfers</td>
<td></td>
</tr>
<tr>
<td>Oral appliances</td>
<td>Aetna must be notified prior to services being rendered.</td>
</tr>
</tbody>
</table>

The phone numbers that you should call for pre-certification are listed on the back of your ID card.

Notes:
Pre-certification is not required for a maternity stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

If you receive pre-certification for one facility, but then you are transferred to another facility, pre-certification is also required before going to the new facility.

Several drugs and medical injectables require pre-certification. This list is subject to change, so please visit the Aetna website for a current list.

How Pre-Certification Works
Before you seek any of the non-emergency services listed above, Aetna will, in conjunction with your doctor, certify the care as appropriate. A non-emergency service is one that can be scheduled in advance. Aetna will determine the number of days of confinement or use of other services authorized for payment. It is important to remember that you are ultimately responsible for obtaining pre-certification. Do not rely on the facility or provider to call for you.
Case Management Service

Case management is a program aimed at promoting more effective treatment for patients with serious or ongoing medical problems (such as spinal cord injury, AIDS, cancer or premature birth). You may require:

- Long or lifetime care;
- Extensive services; or
- Assistance with deciding on a care setting.

Case Management Specialists communicate directly with your doctor to address your medical and psychological needs and to obtain appropriate resources for your care. Many times, quality care from the beginning of a serious illness helps avoid major complications in the future.

How Case Management Works
The patient can request case management services, or in some cases, a Case Management Specialist may contact you if they believe case management services may be beneficial. Case management is a voluntary service. There are no reductions of benefits or penalties if you choose not to participate.

Medical Management Services
The Plan includes health care review procedures performed by Aetna to help you get appropriate medical care in a cost-effective setting. As a result, the benefit amounts payable under the Schedule of Benefits may be affected if the medical management requirements are not met. Medical management services included in the Plan are:

- Utilization Management including Pre-certification;
- Preadmission Testing Service (may apply).

Utilization Management
Utilization management is a formal assessment of health care services as to their:

- Medical necessity;
- Appropriateness; and
- Effectiveness.

The assessment can be conducted:

- Prior to treatment (prospective);
- During treatment (concurrent); or
- Following treatment (retrospective).
Disease Management
This is a voluntary, confidential benefit for employees and their family members who are diagnosed with certain medical conditions. This includes diabetes, heart disease, asthma, osteoporosis, cancer, migraines, lower back pain, etc. In these programs a healthcare professional who specializes in these chronic conditions partners with you and your physician to outline your personal health goals. You will receive an initial phone call to invite you to participate in the program and if you accept you will start to receive periodic phone calls, scheduled at your convenience, to assess where you are in relation to reaching your health goals. You will also receive informative mailings, to provide education about your chronic condition. If you have questions please contact Aetna for more information.

Second and/or Third Opinions
In order to prevent unnecessary or potentially harmful surgical treatments, benefits will be provided for a second (and third, if necessary) opinion consultation to determine the medical necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance and is not an emergency or life threatening. There are no reductions of benefits or penalties if you choose not to participate.

Predetermination of Medical Benefits
You or your physician may submit a written request for a predetermination of benefits. The written request should contain the treatment plan, specific diagnostic and procedure codes, as well as the expected charges. Aetna will provide a written response advising if the services are a covered or non-covered expense under the Plan, what the applicable Plan benefits are and if the expected charges are within the maximum allowable fee. The predetermination of benefits is not a guarantee of benefits. Services will be subject to all terms and provisions of the Plan applicable at the time treatment is provided.

If treatment is to commence more than 180 days after the date treatment is authorized, Aetna will require you to submit another treatment plan.

Nurseline Services
NurseLine provides reliable information and confidential support from registered nurses regarding a wide range of health concerns 24 hours a day, 365 days a year.

Aetna participants: 800-556-1555
Provider Networks

Your coverage provides for the use of a Preferred Provider Organization (PPO). Generally, the Plan pays more benefits when you go to a provider that participates in the PPO network. This provider may be referred to as an “in-network” provider.

You have the right to choose any provider for your care. However, if you choose to use a non-participating provider, you may be responsible for a larger percentage of the total medical expense. This provider may be referred to as an “out-of-network” provider. See the Schedule of Benefits to determine the difference in benefits.

A participating provider (in-network) is a health care provider who entered into an agreement with the PPO to provide services for a negotiated fee. A non-participating provider (out-of-network) doesn’t have an agreement with the PPO and may bill you for additional fees over what the Plan will pay. These fees are called Usual & Customary as further explained in this summary.

Be sure to review the provider directory and ask your provider if they participate in your network. The participation status of providers may change so verify before each appointment. The Aetna websites or customer service representatives will provide an updated listing of providers.

Network Directories

The network is Aetna Choice POS II (Open Access). You may access information regarding networks hospitals, doctors network hospitals, doctors, and other providers by accessing Aetna’s web site at www.aetna.com or calling Aetna’s Customer Service at 800-533-7831.
Prescription Drug Coverage

The prescription drug program has a mandatory generic substitution provision. This means that the pharmacy will automatically dispense the generic version of a medication if one exists, unless your physician specifies “Dispense as Written” on each prescription. You should discuss using generic drugs with your physician whenever possible. By law, they must contain the same active ingredients as brand name drugs, yet they usually cost significantly less.

If you receive a brand name drug when a generic equivalent is available, you will be charged the brand coinsurance (listed above) plus the cost difference between the generic and brand drug. This is true even if the physician writes, “dispense as written” on the prescription.

Aetna has a drug list that allows you to determine which tier your prescription is in. This not only helps you to determine your prescription coinsurance, it is also a resource that your doctor can refer to when considering your prescription choices. To find Aetna’s prescription drug list, visit www.aetna.com.

Participating Pharmacies

The prescription drug program includes a participating network of pharmacies. Prescriptions filled at non-participating pharmacies are not covered. You can contact Aetna to determine if your pharmacy is participating.

Aetna: 800-533-7831 or www.aetna.com

Mail order program

If you take a refillable maintenance medication, the mail order program is the most economical way to get your prescriptions filled. The mail order programs are administered through Aetna.

If you plan to use the mail order program when your doctor prescribes a maintenance drug, be sure to:

- Ask for a prescription for the initial 30-day supply (that you can have filled immediately from a retail pharmacy).
- Ask for a second prescription that allows for a 90-day supply of the prescribed drug with at least one refill. Mail with order form and payment to the mail order center.
- Carefully read your prescriptions when your doctor hands them to you. If he or she does not write the mail order prescription correctly, it will not be filled or may be filled incorrectly.

Mail order information and order forms are available at:

Aetna: 800-533-7831 or go to www.aetna.com
Filing a Prescription Drug Claim
Present your ID card at a participating pharmacy when purchasing a prescription. They will be able to verify coverage immediately and will know what your prescription drug coinsurance is depending upon the drug being dispensed.

You may also pay for the prescription and submit a prescription claim form for reimbursement. Keep in mind, this could result in a higher cost to you.

Claim forms can be found:
Aetna: 800-533-7831; www.aetna.com
Covered Medical Expenses
The Plan provides coverage for the following benefits if services are authorized by a physician and are medically necessary for the treatment of an illness or injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this document:

Allergy testing, vials and injections

Ambulance: Transportation (ground and air) for emergencies or medically necessary transportation to the nearest appropriate facility.

Anesthetics and their administration.

Artificial limbs, eyes, and larynx: When medically necessary for activities of daily living, as a result of an illness or injury. Coverage will be provided for prosthetic devices necessary to restore minimal basic function.

Birthing center: Expenses incurred within 48 hours (96 hours if cesarian section) after confinement in a birthing center for services and supplies furnished for prenatal care and delivery of child(ren).

Blood and blood plasma: As long as it is not replaced by donation and administration of blood and blood products.

Cardiac rehabilitation: Phase I, while the covered person is an inpatient. Phase II, while the covered person is an outpatient. Services generally begin within 30 days after discharge from the hospital.

Chiropractic treatment: By a qualified chiropractor or licensed Osteopath. The detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference or related to distortion, misalignment or subluxation of the vertebrae column.

Cleft palate and cleft lip: Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes medically necessary oral surgery, pregraft palatal expander and related medically necessary orthodontic treatment after surgery.

Cosmetic or reconstructive surgery: Only if the surgery is to restore bodily function or correct deformity resulting from a congenital disease or anomaly of a covered dependent child or from an illness or injury.

Contraceptives: Benefits are payable for contraceptives in the doctor’s office, IUDs, and Depo-Provera injections (refer to Prescription Drug Coverage section for other contraceptive coverage).

Crutches: For rental up to, but not to exceed, the purchase price.
Dental/oral surgery:
- Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
- Surgery required to correct accidental injury to the jaw, cheeks, lips, tongue, floor and roof of the mouth;
- Emergency repair due to injury to sound natural teeth, including but not limited to extraction and initial replacement; repair must be within 12 months from the date of the accident;
- Reduction of fractures and dislocation of the jaw due to accidental injury;
- Excision of benign bony growths of the jaw and hard palate;
- External incision and drainage of cellulitis;
- Incision of sensory sinuses, salivary glands or ducts;
- Excision of partially or completely unerupted impacted teeth;
- Frenectomy (the cutting of the tissue in the midline of the tongue)
- Excision of exostoses;
- Apicoectomy (excision of the apex of the tooth root);
- Alveolectomy (leveling teeth supporting structures for the purpose of fitting dentures);
- Removal of retained residual root;
- Periodontal surgeries (osseous and gingivectomy)
- Apical curettage.


Diagnostic x-ray or laboratory tests

Drugs: Which are administered or dispensed as take home drugs as part of treatment while in the hospital or at a medical facility and that require a physician's prescription.

Durable medical equipment: For rental up to, but not to exceed, the purchase price, of a wheelchair, hospital bed, ventilator, hospital-type equipment or other durable medical equipment (DME). The Plan, at its option, may authorize the purchase of DME in lieu of its rental if the rental price is subject to exceed the purchase price.

Extended care facility services: Room and board, miscellaneous services, supplies and treatments provided by an extended care facility.

Eye diseases: Protective lenses following a cataract operation.

Free-Standing Surgical Facility: Charges made by a free-standing surgical facility for surgical procedures performed and for services rendered.

Genetic testing: Females over age 35, amniocentesis, genetic lab studies, only when medically necessary.

Growth hormones
Hearing deficit: Exams, tests, services and supplies for other than preventive care, to diagnose and treat a medical condition.

Home health care services: Services and supplies only for care and treatment of an injury or illness when hospital or skilled nursing facility confinement would otherwise be required. A home health care visit will be considered to be a periodic visit by either a nurse or therapist or four hours of home health aide services.

Hospice care services: Treatment given at a hospice care facility or in your home, must be in place of a stay in a hospital or extended care facility, and can include: room and board and other services and supplies; part-time nursing care by or supervised by a R.N. for up to eight hours per day; part-time or intermittent home health aide services, consisting primarily of caring for the patient; and counseling services (for the patient and the patient’s immediate family) by a licensed social worker or a licensed pastoral counselor. Patient must be terminally ill with an anticipated life expectancy of approximately six months.

Hospital services (includes inpatient services, ambulatory surgery centers and birthing centers): Semi-private room and board. Any charge over a semi-private room charge will be a covered expense if determined to be medically necessary. Includes: Intensive Care Unit room and board; miscellaneous and ancillary services; and blood and blood plasma.

Hospital services (outpatient)

Insulin infusion pump

Laboratory tests for covered benefits.

Maternity benefits for employees and eligible dependents include: pre-natal and post-natal care; hospital room and board; outpatient birthing center fees; obstetrical fees for routine prenatal care; vaginal delivery or cesarean section; medically necessary diagnostic testing (such as ultrasound and amniocentesis); elective abortion when the life of the mother is in danger; and abdominal operation for intrauterine pregnancy or miscarriage.

Note: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean sections. In addition, the medical plan may not require that a provider obtain authorization for prescribing a length of stay unless greater than 48 hours (or 96 hours as applicable); also, the pre-existing condition exclusion does not apply to pregnancy-related charges.

Mental health treatment: Refer to Schedule of Benefits.

Morbid obesity treatment: Tests or treatment that are medically necessary and appropriate for morbid obesity as defined as 100 pounds over body weight or twice the medically recommended weight for a person of the same height, age and mobility as the
covered person. Services must be administered by an M.D. and include: gastric or intestinal bypasses; gastric balloons; stomach stapling; wiring of the jaw; panniculectomy; liposuction; drugs; and weight loss programs.

**Multiple surgical procedures:** Additional procedures performed through the same incision will be allowed at 50% of the usual and customary charge; procedures unrelated to the diagnosis for the primary procedure will not be covered.

**Newborn benefits:** Covered expenses for well- or sick-newborn incurred during a newborn child’s initial inpatient hospital confinement include hospital expenses for room and board and miscellaneous services; physician expenses for circumcision; and expenses for routine examination before release from the hospital.

**Orthoptics**

**Osteotomy:** Hospital and qualified practitioner related expenses.

**Oxygen and its administration**

**Pharmacological or medication management:** And lab charges for mental health treatment.

**Physician assistant services**

**Physician services:** For covered benefits.

**Prescription medication and product coverage:** Refer to Prescription Drug Coverage section.

**Preventive services:** As listed under the Schedule of Benefits.

**Private duty nursing care** when care is inpatient, medically necessary, not custodial in nature and the hospital's Intensive Care Unit is filled or there is not one available.

**Radiation therapy and chemotherapy**

**Reconstructive Surgery:**
- For an injury, infection or other disease of the involved part; or
- For repair of defects which result from covered surgery; or
- For the Reconstructive (not cosmetic) repair of a congenital defect of a covered dependent which materially corrects a bodily malfunction; or
- Following a mastectomy (complies with the Women's Health and Cancer Rights Act): The covered person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered expenses are reconstructive treatments that include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
**Routine Care:** The following expenses are payable for you or your covered dependent for in-network services, up to the amount shown on the Schedule of Benefits, subject to all terms and provisions of the Plan, except the exclusion for services which are not medically necessary, if you are not confined in a hospital or qualified treatment facility and if such expenses are not incurred for diagnosis of a specific bodily injury or sickness. Out-of-network routine care is not a covered benefit.

**Benefits include:**
1. Routine exams and annual checkups;
2. Immunizations,
3. Pap smears, limited to one per calendar year;
4. Mammograms, limited to one per calendar year ages 40 and over;
5. Routine x-ray and laboratory tests;
6. Prostate antigen testing, limited to one per calendar year for ages 40 and over;
7. Routine cancer screenings (Example, colonoscopy, sigmoidoscopy, proctosigmoidoscopy), ages 50 and over; fecal occult blood test every year, sigmoidoscopy one every five years, double contrast barium enema one every five years, colonoscopy one every five years.

**Skilled nursing facility care:** If the patient is confined as a bed patient; the confinement starts immediately following a hospital stay or a period of home health care; the attending physician certifies that the confinement is needed for further care of the condition that caused the hospital stay; and the attending physician completes a treatment plan.

**Sterilizations (Voluntary)**

**Substance abuse services:** Refer to the Schedule of Benefits.

**Surgery and surgery centers**

**Surgical dressings**

**Therapy services:** Refer to the Schedule of Benefits. This Plan does not cover services that should legally be provided by a school, such as those required under the Individuals with Disabilities Education Improvement Act.
Transplant Services: The Plan will pay benefits for the expense of a transplant as defined below when incurred by a covered person and approved in advance by Aetna.

Only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified below, which are determined by Aetna to be medically necessary services and which are not experimental, investigational or for research purposes. The transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

1. Heart;
2. Lung(s);
3. Heart-lung;
4. Liver;
5. Kidney;
6. Bone Marrow;
7. Intestine;
8. Simultaneous pancreas/kidney;
9. Pancreas following kidney;
10. Any organ not listed above required by state or federal law.

The term bone marrow identified in the foregoing transplant definition refers to the transplant of human blood precursor cells, which are administered to a patient following high-dose, ablative or myelosuppressive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. Storage of cord blood and stem cells will not be covered unless as an integral part of a transplant of bone marrow approved by Aetna.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan benefits and are subject to other applicable provisions of the Plan.

For a transplant to be considered fully approved, prior written approval from Aetna is required in advance of the transplant. You or your physician must notify Aetna in advance of your need for an initial evaluation for the transplant in order for Aetna to determine if the transplant will be covered. For approval of the transplant itself, Aetna must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.
Transplant Covered Services
For approved transplants, and all related complications, Aetna will cover only the following expenses:

1. Hospital benefits shown in the Schedule of Benefits under the Hospital Benefit section. Physician benefits shown in the Schedule of Benefits will be paid at (a) the in-network coinsurance amount, subject to deductible, if received from an in-network provider designated by Aetna as an approved transplant provider; and (b) not covered if received from an out-of-network provider.

2. Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under the Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the covered person, except the reasonable costs of searching for the donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

3. Direct, non-medical costs* for the covered person receiving the transplant will be paid for: (a) transportation to and from the hospital where the transplant is performed; and (b) temporary lodging at a prearranged location when requested by the hospital and approved by Aetna. Transportation costs for the covered person to and from the hospital where the transplant is performed will be paid at: (a) 100% of covered expenses, if the transplant is received at an in-network hospital designated by Aetna. These direct, non-medical costs are only available if the covered person lives more than 100 miles from the transplant facility. Out-of-network services are not covered.

4. Direct, non-medical costs* for one member of the covered person's immediate family (two members if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the transplant is performed to a maximum benefit of $2,000 per procedure; and, (b) temporary lodging at a prearranged location during the covered person's confinement in a hospital, not to exceed $100 per day. Transportation costs for the covered person's immediate family member(s) to and from the hospital where the transplant is performed will be paid at: (a) 100% of covered expenses, if the transplant is received at an in-network hospital designated by Aetna. These direct, non-medical costs are only available if the covered person's immediate family member(s) live more than 100 miles from the transplant facility. Out-of-network services are not covered.

*All direct, non-medical expenses for the covered person receiving the transplant and his/her family member(s) are limited to a combined maximum benefit of $10,000 per transplant.

Once the transplant is approved, Aetna will advise the covered person's physician. Benefits are payable only if the pre-transplant services, the transplant and post-discharge services are approved by Aetna.
Well baby care: Routine well baby care including routine physical exams, laboratory blood tests and immunizations in the hospital.
Other Covered Expenses

The following are other covered expenses payable as shown on the Schedule of Benefits:

1. Oxygen and rental of equipment for its administration;

2. Drugs and medicines required by law to be obtained on the written prescription of a physician when not rendered by a pharmacy;

3. Initial prosthetic devices or supplies, including but not limited to, limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a covered expense if due to pathological changes. Covered expense includes repair of the prosthetic device if not covered by the manufacturer;

4. Casts, trusses, crutches, splints except for dental splints, and braces except for orthodontic braces;

5. Supplies, up to a 30-day supply, when prescribed by your attending physician;

6. Initial contact lenses or eyeglasses following cataract surgery;

7. Installation and use of an insulin infusion pump, diabetic self-management education programs and other equipment or supplies in the treatment of diabetes. Coverage for an insulin infusion pump is limited to the purchase of one pump per calendar year and the pump must be in use for 30 days before purchase;

8. Reconstructive surgery due to bodily injury, infection or other disease of the involved part or congenital disease or anomaly of a covered dependent child which resulted in a functional defect;

9. Reconstructive services following a covered mastectomy, including but not limited to:
   a. reconstruction of the breast on which the mastectomy was performed;
   b. reconstruction of the other breast to achieve symmetry;
   c. prosthesis; and
   d. treatment of physical complications of all stages of the mastectomy, including lymphedemas;

10. Services for morbid obesity, including medically necessary surgical procedures;

11. Private duty nursing, except during an inpatient hospital or hospice confinement.

12. Wigs, up to $500 per plan year, when hair loss is resulting from chemotherapy and/or radiation.
The following services are considered other covered expenses and are payable as shown on the Schedule of Benefits, subject to all terms and provisions of the Plan, except the exclusion for services which are not medically necessary:

1. Elective sterilizations;

2. Birth control devices, injections, or implant systems, including the removal of contraceptive implant systems;

3. Infertility counseling and treatment up to the diagnosis of infertility.
What’s Not Covered
Exclusions, including complications from excluded items are not considered benefits under the Plan and will not be considered for payment. The Plan does not pay for expenses incurred for the following, even if they are considered to be medically necessary by Aetna, unless otherwise stated below.

Note: All exclusions related to prescription drugs are shown in the Prescription Drug Coverage section.

Abortion: Except when the life of the mother is in danger.

Acupuncture: Except when used in lieu of an anesthetic for surgery.

Alcohol: Treatment for an injury or illness that occurred as a result of illegal use of alcohol.

Allergies: Experimental treatment only.

Alopecia: For any expenses incurred for treatment related to loss of hair.

Alternative treatment: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by Aetna.

Autism therapy

Before and after termination: Services, supplies or treatment rendered before coverage begins under this plan or after coverage ends are not covered.

Benefits not specified as covered

Bereavement counseling: Except as provided under the hospice care provision.

Biofeedback

Blood: Products when donated or replaced; whole blood.

Breast augmentation or reduction: Unless it is medically necessary as determined by Aetna, except for breast reconstruction following a mastectomy as required under state or federal law/regulation.

Cardiac rehabilitation: Beyond Phase II.

Chelation therapy: Except for acute arsenic, gold, or mercury or lead poisoning.

Close relative: Services performed by a close relative (mother, father, brother, sister) or by someone who ordinarily lives in the covered person’s home.

Communication: Bills for telephone calls, mailings, faxes, e-mails or any other communications to or from a Physician, Hospital, or other medical provider.
Contact lenses: Except as provided under Other Covered Services.

Cosmetic surgery or treatment: And any medical condition or complication arising from cosmetic surgery, except to correct a congenital anomaly, the effects of traumatic injury, disease or previous therapeutic process, and certain surgeries related to mastectomy and breast reconstruction.

Court-ordered: Any treatment or therapy which is court ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by the Plan.

Criminal activity: Illness or injury to you while you are committing or attempting to commit a felony or misdemeanor, or engaging in an illegal activity or occupation, or while participating in a riot.

Custodial care: Services and supplies, except as part of Home Health Care Plan approved by Aetna.

Dental: Services or supplies in connection with dental work, dental surgery or oral surgery (unless otherwise specifically provided in the Plan) including:

• Treatment or replacement of any tooth or tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or
• Surgery or splinting to adjust dental occlusion.

This exclusion does not apply to hospital charges including professional charges for x-ray, lab and anesthesia, charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures or for setting of a jaw that was fractured or dislocated in an accident.

Disorders: Services in connection with learning disabilities or developmental disorder extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

Education: Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care.

Employment or Worker’s Compensation: An illness or injury arising out of or in the course of any employment, including self-employment, whether or not for wage or profit.

Examinations: Examinations for employment, insurance, licensing or litigation purposes; or sports or recreational activity.

Experimental or investigational: Services, supplies, treatment, facilities or equipment that Aetna determines are experimental or investigational (refer to Experimental or Investigational Definition section).

Eye care: Radial keratotomy, lasik surgery or other eye surgery to correct
near-sightedness or far-sightedness; and routine eye care except as outlined under
the Schedule of Benefits. This exclusion does not apply to lasik patients and soft
lenses or sclera shells intended for use as corneal bandages.

**Family members:** A person who lives with you in your home unless they are a covered
dependent on your medical plan.

**Fitness programs:** General fitness programs, exercise programs, exercise equipment
and health club memberships or other utilization of services, supplies, equipment or
facilities in connection with weight control or bodybuilding.

**Foot care:** Routine foot care and removal of corns, calluses, toenails or subcutaneous
tissue, except when care is prescribed by a physician treating metabolic or peripheral
vascular disease.

**Foreign travel:** If travel is for the sole purpose of obtaining medical services.

**Gender change**

**Genetic counseling:** Studies, testing or surgery based only on a family history of
having a disease, rather than on medical necessity for an existing medical problem.

**Government coverage:** Care, treatment or supplies furnished by a government
program or agency, except for:

- The Veterans Administration, when services are provided to a veteran for a disability
  which is not service-connected;
- A military Hospital or facility, when services are provided to a retiree (or dependent of
  a retiree) from the armed services;
- A group health plan established by the government or its agencies for its own
  civilian employees and their dependents; or
- Medicaid, if required by a Medicaid assignment of benefits.

**Hazardous recreational activity:** Care and treatment of an injury or illness that results
from engaging in a hazardous hobby or activity that is characterized by a constant threat
of danger or risk of bodily harm.

**Hearing devices:** The purchase or fitting of hearing aids, Soundtec implants.

**Hearing exam:** Routine hearing exam.

**Home deliveries (maternity)**

**Hospice care program:** Hospice care benefits do NOT include:
1. Private duty nursing services when confined in a hospice facility;
2. A confinement not required for pain control or other acute chronic symptom
   management;
3. Funeral arrangements;
4. Financial or legal counseling, including estate planning or drafting of a will;
5. Homemaker or caretaker services, including a sitter or companion services;
6. Housecleaning and household maintenance;
7. Services of a social worker other than a licensed clinical social worker;
8. Services by volunteers or persons who do not regularly charge for their services; or
9. Services by a licensed pastoral counselor to a member of his or her congregation when services are in the course of the duties to which he or she is called as a pastor or minister.

**Incarceration:** Services and supplies incurred by an Insured Person while incarcerated in a jail, penitentiary, correctional facility or Hospital.

**Illegal drugs:** Treatment for an injury or illness resulting from being voluntarily under the influence of any controlled substance or drug that is not prescribed by a physician.

**Immunizations:** For foreign travel unless required by Manpower.

**Infertility drugs and treatment:** Other than to determine diagnosis, including, but not limited to:
- Fertility tests and procedures
- Any similar method or treatment which attempts to cause conception or pregnancy by hormone therapy, artificial insemination, in vitro fertilization, gift, and/or embryo transfer.

**Massage therapy or aquatic therapy**

**Medical Department:** Services supplied through an employer, a mutual benefit association, a labor union, a trust or similar entity.

**Midwife:** Services of a midwife are not covered, unless provided by a Certified Nurse Midwife.

**Military:** A military-related illness or injury caused by any act or incident of declared or undeclared war, riots, insurrection or acts of terrorism or sustained by a covered person of the armed services of any country while on active duty.

**Non-emergency hospital admissions:** On a Friday or Saturday unless surgery is performed within 24 hours of admission.

**Non-health care practitioners:** Who are not licensed health care providers.

**No obligation to pay:** Charges incurred for which the Plan and the participant has no legal obligation to pay.
**No physician recommendation:** Treatment not recommended and approved by a physician or when the covered person is not under the regular care of a physician.

**No-Fault state:** Benefits are not payable under the Plan for any illness/injury received in an accident involving a car or other major vehicle for participants who are residents of a no-fault state and eligible for benefits under the no-fault motor vehicle law, until the benefits under no-fault have been exhausted.

**Non-medical services:** Which are primarily for the Insured Person’s convenience or comfort or that of the Insured Person’s family, caregiver, companion, sitter, Physician or other person, including: personal hygiene, cosmetic and convenience items such as air conditioners, humidifiers, exercise equipment, elevators or ramps; or personal comfort items, even when used by a covered individual in an inpatient health care facility, such as telephones, televisions, guest trays or laundry charges.

**Not medically necessary:** Services, supplies, treatment, facilities or equipment that are determined to be not medically necessary by Aetna.

**No injury or illness:** Services and supplies that are not the result of injury or Sickness excluding routine care.

**Not specified as covered:** Services, treatments and supplies that are not specified as covered under the Plan, even if considered medically necessary, except general anesthesia and associated hospital or ambulatory health care facility charges in conjunction with dental services as described in this SPD.

**Nutritional counseling:** excluding services for diabetes management and prior to approved bariatric surgery.

**Orthopedic items:** Charges, exam for the prescription or fitting for shoe orthotics, orthopedic shoes or arch-supports.

**Out of scope:** Providers acting beyond the scope of their practice area.

**Plan design excludes:** Charges excluded by the Plan design.

**Penile pumps/erectaid devices**

**Personal comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

**Professional Standards:** Services or supplies, which are not provided in accordance with generally accepted professional standards and/or medical practice.

**Reconstructive surgery:** Performed only to achieve a normal or nearly normal appearance, or any portion thereof, as determined by Aetna, except for congenital illness or anomaly which resulted in a functional defect; abnormality resulting from an accident; abnormality resulting from infection or other disease of the involved part; or breast reconstruction following a mastectomy.
Repairs: Maintenance or repair of durable medical equipment due to abuse or misuse of equipment.

Replacement braces: Unless there is sufficient change in a physical condition that makes the original device non-functional.

Reversal of sterilization: Procedures or treatments to reverse prior voluntary sterilization.

Rolfing Muscular Manipulation

Sales tax, shipping and handling

School System: Services or supplies provided or available through an agent of a school system in response to the requirements of the Individuals with Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students with the educational system, even when such services are considered covered services when provided outside the educational domain.

Self-care or self-help: Training designed to help you cope with a health problem or to modify behavior or improvement of health, except as coordinated through managed care.

Self-Inflicted: When intentional and not inflicted as a result of a medical condition.

Separate billings: For surgical procedures, medical services or supplies furnished by an employee or provider which are normally included in the provider’s charges and billed for them.

Services at no cost: Services that the covered person would not be obligated to pay in the absence of the Plan or which are available to the covered person at no cost, except for care as required by law.

Sexual and gender identity disorders: Including but not limited to sexual dysfunctions, paraphilias, or gender transformations.

Sexual dysfunction treatment: Not related to organic disease, or a medical condition arising from such treatment.

Sleep disorders: Unless deemed medically necessary.

Smoking cessation: Except as provided under the Manpower smoking cessation program.

Specific provider type services under medical plan: Services for: Physicians Assistant (unless supervised and billed by a physician or doctor).

Specific provider type services for mental health treatment: Services for: therapist with a PhD or master's degree in psychiatry; State licensed psychologist; State licensed or certified Social Worker; Licensed Practical Clinician; or Certified addiction counselor (for
substance abuse), unless supervised and billed by a physician or doctor.

**Supplements:** All eternal feedings, supplemental feedings, over-the-counter nutritional and electrolyte supplements and related supplies including feeding tubes, pumps, bags and products except enteral formulas for the treatment of genetic metabolic disease, e.g. phenylketonuria, (PKU).

**Temporomandibular Joint Syndrome:** Not covered except for treatment medical-in nature (including exams, x-rays, injections, anesthetics, physical therapy and oral surgery for TMJ). Excludes appliance therapy and tooth reconstruction.

**Therapies:** Designed to promote personal growth or enhancement absent a diagnosis of Mental and Nervous Disorder/Alcohol and Substance Abuse.

**Third-Party actions:** Injuries or illnesses caused by a third party.

**Tinnitus maskers**

**Transplant Exclusions:** No benefit is payable for or in connection with a transplant if:

1. It is experimental, investigational or for research purposes as defined elsewhere in the Plan.

2. Aetna is not contacted for authorization prior to referral for evaluation of the transplant, unless Aetna waives such authorization.

3. Aetna does not approve coverage for the transplant, based on its established criteria.

4. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.

5. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the Plan.

6. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the Plan.

7. A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant.

8. The covered person for whom a transplant is requested has not met pre-transplant criteria as established by Aetna.

**Travel:** Even if advised by a health care practitioner, except as covered for organ transplants.

**Usual and customary charges:** Charges that are in excess of the usual and customary
charge or the negotiated fee.

**Vitamins, minerals and dietary supplements:** except enteral formulas for the treatment of genetic metabolic disease, e.g. phenylketonuria, (PKU).

**Vocational testing, evaluation and counseling:** Vocational and educational services rendered primarily for training or education purposes.

**Act of War:** Services or supplies related to an act of declared war or armed aggression; or which:

- Is incurred while the Covered Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and
- For which any governmental body or its agencies are liable.

**Filing A Medical Claim**

Present your benefits ID card to the hospital admissions clerk or provider's office. Most providers will submit claims on your behalf, except for the co-pays that you need to pay upfront, if applicable. If not, you will need to send the claim to Aetna within 12 months from the date of the claim.

At a minimum, claims must contain:

a. The name of the covered person who incurred the covered expense;
b. The name and address of the health care provider;
c. The diagnosis of the condition;
d. The procedure or nature of the treatment;
e. The date of and place where the procedure or treatment has been or will be provided;
f. The amount billed and the amount of the covered expense not paid through coverage other than Plan coverage, as appropriate;
g. Evidence that substantiates the nature, amount, and timeliness of each covered expense in a format that is acceptable according to industry standards and in compliance with applicable law.

**Fee Schedule**

Providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any deductible, co-pay, coinsurance or penalties that you are responsible for paying.

**Negotiated Rate**

On occasion, Aetna will negotiate a payment rate with a provider for a particular covered service such as transplant services, durable medical equipment, extended care or other services. The negotiated rate is what the Plan will pay to your provider, minus any co-pay, deductible, coinsurance rate or penalties that you are responsible for paying.

**Usual, Reasonable and Customary (U&C)**

Is the amount that is usually charged by health care providers in the same geographical area for the same services, treatment or materials.

**Participating/Non-participating Provider Fees**

Participating providers have agreed to accept payments from the Plan as payment in
full, except for the amounts that you owe due to deductible, co-pay, participation amounts or penalties.

Non-participating providers have no agreement with the Plan to accept the Plan’s payment as payment in full. You will need to pay the difference between what the Plan pays and the full non-discounted billed amount from the non-participating provider.

**Payment of Benefits**
Payment for covered medical benefits will be paid to the provider if you have assigned benefits directly to the provider.

**Explanation of Benefits (EOB)**
Each time a claim is submitted by you or your provider, you will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid towards the claim, and how much of the claim is your responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions.

Please check the information on each Explanation of Benefits to make sure you actually received those services from the provider and that the information appears correct. If you have any questions or concerns about the EOB, please feel free to call Aetna at the number listed on the EOB or on the back of your ID card. Your provider will receive a similar form on each claim that is submitted.

**Medical Privacy**
Medical information that is obtained and maintained in the course of processing claims will be secured and protected in accordance with state and federal laws regarding participant privacy rights.

**Circumstances Causing Loss or Denial of Plan Benefits**
Claims can be denied for the following reasons:

- Termination of your employment;
- You or your dependents are no longer eligible for coverage under the health plan;
- Charges incurred prior to or following your effective date of coverage;
- You reached an annual benefit maximum benefit for that service under the Plan;
- Expiration of a collective bargaining agreement;
- Amendment of the group health plan;
- Termination of the group health plan;
- Employee, dependent or provider did not respond to the Plan's request for additional information needed to process the claim or appeal;
- Application of coordination of benefits provisions;
- Enforcement of subrogation;
- Non-duplication of disability benefits;
- Services are not a covered benefit under the Plan;
- Cosmetic surgery or treatment, as determined by Aetna;
- Services are not considered medically necessary;
- Failure to have required services pre-certified (reduction)
- Misuse of the plan ID card or other fraud;
- Failure to pay premiums if required;
• Employee or dependent is responsible for charges due to deductible, co-pay, participation obligations or penalties;
• Application of usual and customary fee limits;
• No coverage for certain services due to use of non-participating providers;
• Incomplete claim submission;
• Application of utilization review;
• Experimental or investigational procedure;
• Services which are not performed by an eligible provider; and
• Other reasons as stated elsewhere in this document.

Certificates Of Creditable Coverage

You will receive a certificate of creditable coverage from the Plan when:

• You lose coverage under Manpower's Medical Plan;
• When you lose COBRA coverage; or
• You give the Medical Plan a written request within 24 months after coverage ends.

You are encouraged to keep these certificates in a safe place in case you get coverage under another health plan that has a pre-existing conditions exclusion. By proving that you had prior creditable coverage, you may be able to have the pre-existing conditions exclusion period reduced or eliminated. Creditable coverage is only counted if there is less than a 63-day break in coverage between the date this coverage ends and the date your new coverage begins. Waiting periods do not count toward the 63-day break in coverage.
Claims Procedures
After submission of a claim, Aetna will notify the claimant within a reasonable time, as follows:

Pre-service Claims
Aetna will notify the claimant of a favorable or adverse benefit determination within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan.

However, this period may be extended by an additional 15 days, if Aetna determines that the extension is necessary due to matters beyond the control of the Plan. Aetna will notify the affected claimant of the extension before the end of the initial 15-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the claimant's failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The claimant will have at least 45 days from the date the notice is received to provide the specified information.

Urgent Care Claims
Aetna will determine whether a claim is an urgent care claim. This determination will be made on the basis of information furnished by or on behalf of a claimant. In making this determination, Aetna will exercise its judgment, with deference to the judgment of a physician with knowledge of the claimant's condition. Accordingly, Aetna may require a claimant to clarify the medical urgency and circumstances that support the urgent care claim for expedited decision-making.

Aetna will notify the claimant of a favorable or adverse benefit determination as soon as possible, taking into account the medical exigencies particular to the claimant's situation, but not later than 72 hours after receipt of the urgent care claim by the Plan.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the Plan, notice will be provided by Aetna as soon as possible, but not more than 24 hours after receipt of the urgent care claim by the Plan. The notice will describe the specific information necessary to complete the claim.

- The claimant will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than 48 hours.

- Aetna will notify the claimant of the Plan's urgent care claim determination as soon as possible, but in no event more than 48 hours after the earlier of:
  a. The Plan's receipt of the specified information; or
  b. The end of the period afforded the claimant to provide the specified additional information.

Post-service Claims
Aetna will notify the claimant of a favorable or adverse benefit determination within a reasonable time, but not later than 30 days after receipt of the claim by the Plan.
However, this period may be extended by an additional 15 days, if Aetna determines that the extension is necessary due to matters beyond the control of the Plan. Aetna will notify the affected claimant of the extension before the end of the initial 30-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the claimant’s failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The claimant will have at least 45 days from the date the notice is received to provide the specified information. Aetna will make a decision no later than 15 days after the earlier of the date on which the information provided by the claimant is received by the Plan or the expiration of the time allowed for submission of the additional information.

**Miscellaneous Medical Charges**
If you accumulate bills for medical items you purchase or rent yourself, send them to Aetna at least once every three months during the year (quarterly). The receipts must include the patient name, name of item, date item purchased or rented and name of the provider of service.

**Procedural Defects**
If a pre-service claim submission is not made in accordance with the Plan's procedural requirements, Aetna will notify the claimant of the procedural deficiency and how it may be cured no later than within five (5) days (or within 24 hours, in the case of an urgent care claim) following the failure. A post-service claim that is not submitted in accordance with these claims procedures will be returned to the submitter.

**Assignments and Representatives**
A covered person may assign his or her right to receive Plan benefits to a health care provider only with the consent of Aetna in its sole discretion, except as may be required by applicable law. Assignments must be in writing. If a document is not sufficient to constitute an assignment, as determined by Aetna, then the Plan will not consider an assignment to have been made. An assignment is not binding on the Plan until Aetna receives and acknowledges in writing the original or copy of the assignment before payment of the benefit.

If benefits are assigned in accordance with the foregoing paragraph and a health care provider submits claims on behalf of a covered person, benefits will be paid to that health care provider.

In addition, a covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The designation must be explicitly stated in writing and it must authorize disclosure of Protected Health Information with respect to the claim by the Plan, Aetna and the authorized representative to one another. If a document is not sufficient to constitute a designation of an authorized representative, as determined by Aetna, then the Plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.
• Any document designating an authorized representative must be submitted to Aetna in advance, or at the time an authorized representative commences a course of action on behalf of a claimant. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the claimant to the claimant, which Aetna may verify with the claimant prior to recognizing the authorized representative status.

• In any event, a health care provider with knowledge of a claimant’s medical condition acting in connection with an urgent care claim will be recognized by the Plan as the claimant’s authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.
Time For Decisions
The periods of time for claims decisions presented above begin when a claim is received by the Plan, in accordance with these claims procedures.

Payment of Claims
Many health care providers will request an assignment of benefits as a matter of convenience to both provider and patient. Also as a matter of convenience, Aetna will, in its sole discretion, assume that an assignment of benefits has been made to certain Network Providers. In those instances, Aetna will make direct payment to the hospital, clinic, or physician's office, unless Aetna is advised in writing that you have already paid the bill. If you have paid the bill, please indicate on the original statement, "paid by employee," and send it directly to Aetna. You will receive a written explanation of the benefit determination. Aetna reserves the right to request any information required to determine benefits or process a claim. You or the provider of services will be contacted if additional information is needed to process your claim.

When an employee's child is subject to a medical child support order, Aetna will make reimbursement of eligible expenses paid by you, the child, the child's non-employee custodial parent, or legal guardian, to that child or the child's custodial parent, or legal guardian, or as provided in the medical child support order.

Payment of benefits under the Plan will be made in accordance with an assignment of rights for you and your dependents as required under state Medicaid law.

Benefits payable on behalf of you or your covered dependent after death will be paid, at the Plan's option, to any family member(s) or your estate Aetna will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

Any payment made by Aetna in good faith will fully discharge it to the extent of such payment.

Payments due under the Plan will be paid upon receipt of written proof of loss.
**Concurrent Care Decision**
Aetna will notify the claimant of a concurrent care decision that involves a reduction in or a termination of benefits that have been pre-authorized. Aetna will provide the notices in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of the adverse benefit determination before the benefit is reduced or terminated.

A request by a claimant to extend a course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided by Aetna as soon as possible, taking into account the medical urgency. Aetna will notify a claimant of the benefit determination, whether adverse or not, which 24 hours after receipt of the claim by the Plan, provided the claim is submitted to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

**Notices – General Information**
A notice of an adverse benefit determination or final internal adverse benefit determination will include information that sufficiently identifies the claim involved, including:

1. The date of service;
2. The health care provider;
3. The claim amount, if applicable;
4. The diagnosis code (e.g. ICD-9) and its corresponding meaning;
5. The treatment code (e.g. CPT code) and its corresponding meaning;
6. The reason(s) for the adverse benefit determination or final internal adverse benefit determination to include the denial code (e.g. CARC) and its corresponding meaning as well as a description of this Plan’s standard (if any) that was used in denying the claim. For a final internal adverse benefit determination, this description must include discussion of the decision;
7. A description of available internal appeals and external review processes, including information on how to initiate an appeal; and
8. Disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with internal claims and appeals, and external review processes.

**Initial Denial Notices**
Notice of a claim denial (including a partial denial) will be provided to claimants by mail, postage prepaid, by FAX, or by e-mail, as appropriate, within the time frames noted above.

However, notices of adverse decisions involving urgent care claims may be provided to a claimant orally within the time frames noted above for expedited urgent care claim decisions. If oral notice is given, written notification will be provided to the claimant no later than 3 days after the oral notification.

A claims denial notice will state the specific reason or reasons for the adverse benefits determination, the specific Plan provisions on which the determination is based, and a description of the Plan’s review procedures and associated timeline. The notice will also include a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such
material or information is necessary.

The notice will describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a claimant free of charge upon request.

If the adverse benefits determination is based on medical necessity, experimental, investigational or for research purposes, or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse decision of an urgent care claim, the notice will provide a description of the Plan's expedited review procedures applicable to such claims.
Appeal Of Adverse Benefit Determinations

A claimant must appeal an adverse benefit determination within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a claimant by means of written application to Aetna, in person, or by mail, postage prepaid.

However, a claimant on appeal may request an expedited appeal of an adverse urgent care claim decision orally or in writing. In such case, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person that made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim.

A claimant may review relevant documents free of charge, and may submit issues and comments in writing. In addition, a claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial being appealed was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational or for research purposes or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time Period for Decision on Appeals
Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent Care Claims
As soon as possible, but not later than 72 hours after Aetna has received the appeal request. (If oral notification is given, written notification will follow in hard copy or electronic format within the next three days.)

Pre-Service Claims
Within a reasonable period, but not later than 30 days after Aetna has received the appeal request.

Post-Service Claims
Within a reasonable period, but not later than 60 days after Aetna has received the appeal request.

Concurrent Care Decisions
Within the time periods specified above, depending on the type of claim involved.
Appeal Denial Notices

Notice of a benefit determination on appeal will be provided to claimants by mail, postage prepaid, by FAX, or by e-mail, as appropriate, within the time frames noted above.

A notice that a claim appeal has been denied will state the specific reason or reasons for the adverse benefit determination and the specific Plan provisions on which the determination is based.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim on appeal. A copy of the rule, protocol or similar criterion relied upon will be provided to a claimant free of charge upon request.

If the adverse benefit determination is based on medical necessity, experimental, investigational or for research purposes or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the event of a denial of an appealed claim, the claimant on appeal will be entitled to receive upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination;
2. Submitted, considered or generated in the course of making the benefit determination;
3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations;
4. That constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on.

Exhaustion

Upon completion of the appeals process under this section, a claimant will have exhausted his or her administrative remedies under the Plan. If Aetna fails to complete a claim determination or appeal within the time limits set forth above, the claimant may treat the claim or appeal as having been denied, and the claimant may proceed to the next level in the review process. After exhaustion, a claimant may pursue any other legal remedies available to him or her, which may include bringing a civil action under ERISA § 502(a) for judicial review of the Plan's determinations. Additional information may be available from a local U.S. Department of Labor Office.
Standard External Review

Request for an External Review
A claimant may file a request for an external review with Aetna within 4 months after the date the claimant received an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date 4 months after the notice date, the request must be filed by the first day of the 5th month following receipt of the notice. If the last filing date falls on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday.

The request for an external review must be made by a claimant by means of written application by mail (postage prepaid).

Preliminary Review
Within 5 business days following receipt of a request for external review, Aetna must complete a preliminary review of the request to determine the following:

1. If the claimant is, or was, covered under this Plan at the time the health care item or service was requested or provided;
2. If the adverse benefit determination or final internal adverse benefit determination relates to the claimant’s failure to meet this Plan’s eligibility requirements;
3. If the claimant has exhausted this Plan’s internal appeals process, when required; and
4. If the claimant has provided all the information and forms required to process an external review.

Within 1 business day after completion of the preliminary review, Aetna must provide written notification to the claimant of the following:

1. If the request is complete but not eligible for external review. The notice must include the reason(s) for its ineligibility and contact information for the Department of Labor (DOL) employee Benefits Security Administration (EBSA), including this toll-free number: 1-866-444-EBSA (3272).
2. If the request is not complete. The notice must describe the information or materials needed to make it complete, and Aetna must allow the claimant to perfect the external review request within whichever of the following two options is later:
   a. The initial 4-month filing period; or
   b. The 48-hour period following receipt of the notification.

Referral to an Independent Review Organization (IRO)
Aetna must assign an independent IRO that is accredited by URAC, or another nationally –recognized accreditation organization to conduct the external review. Aetna must attempt to prevent bias by contracting with at least 3 IROs for assignments and rotate claims assignments among them, or incorporate some other independent method for IRO selection (such as random selection). The IRO may not be eligible for financial incentives based on the likelihood that the IRO will support the denial of benefits.
The contract between Aetna and the IRO must provide for the following:

1. The assigned IRO will use legal experts where appropriate to make coverage determinations.

2. The assigned IRO will timely provide the claimant with written notification of the requestor’s eligibility and acceptance of the request for external review. This written notice must inform the claimant that he/she may submit, in writing, additional information that the IRO must consider when conducting the external review to the IRO within 10 business days following the date the notice is received by the claimant. The IRO may accept and consider additional information submitted after 10 business days.

3. Aetna must provide the IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination within 5 business days after assigning the IRO. Failure to timely provide this information must not delay the conduct of the external review—the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination if this Plan fails to timely provide this information. The IRO must notify the claimant and Aetna within 1 business day of making the decision.

4. If the IRO receives any information from the claimant, the IRO must forward it to Aetna within 1 business day. After receiving this information, Aetna may reconsider its adverse benefit determination or final internal adverse benefit determination. If Aetna reverses or changes its original determination, Aetna must notify the claimant and the IRA, in writing, within 1 business day. The assigned IRO will then terminate the external review.

5. The IRO will review all information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during Aetna’s internal claims and appeals process. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following when reaching a determination:
   a. The claimant’s medical records;
   b. The attending health care professional’s recommendation;
   c. Reports from the appropriate health care professional(s) and other documents submitted by Aetna, claimant, or claimant’s treating provider;
   d. The terms of the claimant’s plan to ensure the IRO’s decision is not contrary, unless the terms are inconsistent with applicable law;
   e. Appropriate practice guidelines, including applicable evidence-based standards that may include practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
   f. Any applicable clinical review criteria developed and used by this Plan, unless inconsistent with the terms of this Plan or with applicable law; and
   g. The opinion of the IRO’s clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the reviewer(s) consider them appropriate.

6. The assigned IRO must provide written notice of the final external review decision within 45 days after receiving the external review request to the
claimant and Aetna. The decision notice must contain the following:

a. A general description of the reason an external review was requested, including information sufficient to identify the claim, including:
   i. The date(s) of service;
   ii. The health care provider;
   iii. The claim amount (if applicable);
   iv. The diagnosis code and its corresponding meaning;
   v. The treatment code and its corresponding meaning; and
   vi. The reason for the previous denial.

b. The date the IRO received assignment to conduct the external review and the date of the IRO decision;
c. References to the evidence or documentation considered in reaching the decision, including the specific coverage provisions and evidence-based standards;
d. A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards relied on in making the decision;
e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either Aetna or the claimant;
f. A statement that judicial review may be available to the claimant; and

g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA (section 2793 of PHSA, as amended).

7. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by the claimant, Aetna, or state/federal oversight agency(ies) upon request, except where such disclosure would violate state or federal privacy laws.

Reversal of this Plan’s Decision
If Aetna receives notice of a final external review decision that reverses the adverse benefit determination or final internal adverse benefit determination, it must immediately provide coverage or payment for the affected claim(s). This includes authorizing or paying benefits.
Expeditied External Review

Request for an Expedited External Review
Aetna must allow a claimant to make a request for an expedited external review at the time the claimant receives:

1. An adverse benefit determination involving a medical condition of the claimant for which the time frame for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant’s ability to regain maximum function and the claimant has filed a request for an expedited external review; or

2. A final internal adverse benefit determination involving a medical condition where:
   a. The time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant’s ability to regain maximum function; or
   b. The final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from the facility.

A request for an expedited external review must be made by a claimant by means of written application, by mail (postage pre-paid) and addressed to Aetna.

Preliminary Review
Aetna must determine whether the request meets the reviewability requirements for a standard external review immediately upon receiving the request for an expedited external review. Aetna must immediately send a notice of its eligibility determination regarding the external review request that meets the requirements under the Standard External Review, Preliminary Review section.

Referral to an Independent Review Organization (IRO)
If Aetna determines that the request is eligible for external review, Aetna will assign an IRO as required under the Standard External Review, Referral to an Independent Review Organization (IRO) section. Aetna must provide or transmit all necessary documents and information considered when making adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically, by telephone/fax, or any other expeditious method.

The assigned IRO, to the extend the information is available and the IRO considers it appropriate, must consider the information or documents as outlined for the procedures for standard external review described in the Standard External Review, Referral to an Independent Review Organization (IRO) section. The assigned IRO is not bound by any decisions or conclusions reached during this internal claims and appeals process when reaching its decision.

Notice of Final External Review Decision
The IRO must provide notice of the final external review decision as expeditiously as
the claimant's medical condition or circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review, following the notice requirements outlined in the Standard External Review, Referral to an Independent Review Organization (IRO) section. If the notice is not in writing, written confirmation of the decision must be provided within 48 hours to the claimant and Aetna.

**Right To Require Medical Exams**
The Plan has the right to require that a medical exam be performed on any claimant for whom a claim is pending as often as may be reasonably required. If the Plan requires a medical exam, it will be performed at the Plan's expense. The Plan also has a right to request an autopsy in the case of death, if state law so allow.

**Legal Actions And Limitations**
No action at law or inequity may be brought with respect to Plan benefits until all remedies under the Plan have been exhausted and then prior to the expiration of the applicable limitations period under applicable law.

**Important Notice For Employees And Spouses Age 65 And Over**
Federal law may affect your coverage under the Plan. The Medicare as Secondary Payer rules were enacted by an amendment to the Social Security Act. Also, additional rules which specifically affect how a large group health plan provides coverage to employees (or their spouses) over age 65 were added to the Social Security Act and to the Internal Revenue Code.

Generally, the health care plan of an employer that has at least 20 employees must operate in compliance with these rules in providing plan coverage to plan participants who have “current employment status” and are Medicare beneficiaries, age 65 and over.

Persons who have “current employment status” with an employer are generally employees who are actively working and also persons who are NOT actively working as follows:

- Individuals receiving disability benefits from an employer for up to 6 months, or
- Individuals who retain employment rights and have not been terminated by Manpower and for whom Manpower continues to provide coverage under the Plan. (For example, employees who are on an approved leave of absence.)

If you are a person having “current employment status” who is age 65 and over (or the dependent spouse age 65 and over of an employee of any age), your coverage under the Plan will be provided on the same terms and conditions as are applicable to employees (or dependent spouses) who are under the age of 65. Your rights under the Plan do not change because you (or your dependent spouse) are eligible for Medicare coverage on the basis of age, as long as you have “current employment status” with your employer.

You have the option to reject plan coverage offered by your employer, as does any eligible employee. If you reject coverage under your employer's Plan, coverage is terminated and your employer is not permitted to offer you coverage that supplements
Medicare covered services.

If you (or your dependent spouse) obtain Medicare coverage on the basis of age, and not due to disability or end-stage renal disease, the Plan will consider its coverage to be primary to Medicare when you have elected coverage under the Plan and have “current employment status”.

If you have any questions about how coverage under the Plan relates to Medicare coverage, please contact your employer.

Other Information
Additional information regarding rights and obligations under the Plan and under federal law may be obtained by contacting Benefits or Aetna.

It is important for the covered person or qualified beneficiary to keep Aetna and Plan Manager informed of any changes in marital status, or a change of address.

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify Manpower of any changes in marital status, or a change of address.

Right of Recovery
The Plan reserves the right to recover benefit payments made for an allowable expense under the Plan in the amount which exceeds the maximum amount the Plan is required to pay under these provisions. This right of recovery applies to the Plan against:

1. Any person(s) to, for or with respect to whom, such payments were made; or
2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

The Plan alone will determine against whom this right of recovery will be exercised.
General Provisions

The following provisions are to protect your legal rights and the legal rights of the Plan.

Contestability
The Plan has the right to contest the validity of your coverage under the Plan at any time.

Right to Request Overpayments
The Plan reserves the right to recover any payments made by the Plan that were:

1. Made in error; or
2. Made to you or any party on your behalf where the Plan determines the payment to you or any party is greater than the amount payable under the Plan.

The Plan has the right to recover against you if the Plan has paid you or any other party on your behalf.

Workers’ Compensation Not Affected
The Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers’ Compensation or Occupational Disease Act or Law.

Workers’ Compensation
If benefits are paid by the Plan and the Plan determines you received Workers’ Compensation for the same incident, the Plan has the right to recover as described under the Reimbursement/Subrogation provision. The Plan will exercise its right to recover against you even though:

1. The Workers’ Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that bodily injury or sickness was sustained in the course of or resulted from your employment;
3. The amount of Workers’ Compensation due to medical or health care is not agreed upon or defined by you or the Workers’ Compensation carrier;
4. The medical or health care benefits are specifically excluded from the Workers’ Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Plan, you will notify Aetna of any Workers’ Compensation claim you make, and that you agree to reimburse the Plan as described above.

Medicaid
This Plan will not take into account the fact that an employee or dependent is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying claims.

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment would otherwise be due under the Plan, payment of benefits under the Plan will be made in accordance with a state law which provides that the state has acquired the rights with respect to a covered employee to the benefits payment.
Construction of Plan Terms
Aetna has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the Plan, including, without limitation, the benefits provided thereunder, the obligations of the beneficiary and the recovery rights of the Plan; such construction and prescription by Aetna shall be final and uncontestable.

Qualified Medical Child Support Order
A Medical Child Support Order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency that:

- Provides for child support with respect to your child(ren) under a group health plan or provides for health benefit coverage for your child(ren), and
- Is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Company’s healthcare plan.

A Qualified Medical Child Support Order creates or recognizes the existence of an Alternate Recipient’s rights to – or assigns to an Alternate Recipient the right to – receive benefits for which you are eligible under the Company’s health care plans. To be “qualified”, a Medical Child Support Order also must:

- State your name and last known mailing address (if any) and the name and mailing address of each Alternate Recipient covered by the Order,
- Provide a reasonable description of the type of coverage to be provided by the Plan or a reasonable description of the manner in which such coverage is to be determined,
- State the period to which the Order applies, and
- Specify the Plans to which it applies.

An Alternate Recipient is each of your children who are recognized under the Medical Child Support Order as having a right to enroll under a Manpower health plan.

Upon receipt of a Medical Child Support Order, the Plan Administrator will:

- Notify you and each Alternate Recipient that the Order has been received, and
- Inform you and each Alternate Recipient in writing within a reasonable period whether or not the Order has been determined to be “qualified.”

If the Medical Child Support Order is found to be “qualified,” the Plan Administrator will notify your Corporate Benefits Department to make payments to:

- The appropriate Alternate Recipient,
- His or her custodial parent or legal guardian, or
- To any healthcare provider or facility, if benefits have been assigned.
The Women’s Health and Cancer Rights Act
The Women’s Health and Cancer Rights Act of 1988 mandates that all group health plans providing coverage for mastectomies also cover:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedema.

Your Manpower Plan does cover mastectomies and, therefore, it covers the services listed above as well.

The Newborns’ and Mothers’ Health Protection Act of 1996
The Newborns’ and Mothers’ Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medicare Part D Notice??
Important Terms You Should Know

**Accident** means a sudden event that results in a bodily injury and is exact as to time and place of occurrence.

**Active status** means the employee is performing on a regular, full-time basis all customary occupational duties for 30 hours per week, at the employer’s business locations or when required to travel for the employer’s business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed active status if you were in an active status on your last regular working day prior to the vacation or holiday.

**Admission** means entry into a facility as a registered bed patient according to the rules and regulations of that facility. An admission ends when you are discharged, or released, from the facility and are no longer registered as a bed patient.

**Advanced imaging**, for the purpose of this definition, means Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT) and Computed Tomography (CT) imaging.

**Adverse benefit determination**, means a denial, reduction, or termination, or failure to provide or make payment (in whole or in part) for a benefit, including:

1. A determination based on a covered person’s eligibility to participate in this Plan;
2. A determination that a benefit is not a covered benefit;
3. The imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit; or
4. A determination resulting from the application of any utilization review, such as the failure to cover an item or service because it is determined to be experimental/investigational or not medically necessary.

An adverse benefit determination also includes any rescission of coverage (whether or not in connection with the rescission, there is an adverse effect on any particular benefit at that time).

**Alternative medicine** means an approach to medical diagnosis, treatment or therapy that has been developed or practiced NOT using the generally accepted scientific methods in the United States of America. For purposes of this definition, alternative medicine shall include, but is not limited to: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine,
homeopathy, hypnosis, macrobiotics, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu and yoga.

**Ambulance** means a professionally operated vehicle, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person’s sickness or bodily injury. Use of the ambulance must be medically necessary and/or ordered by a qualified practitioner.

**Ambulatory surgical center** means an institution that meets all of the following requirements:

1. It must be staffed by physicians and a medical staff which includes registered nurses;
2. It must have permanent facilities and equipment for the primary purpose of performing surgery;
3. It must provide continuous physicians’ services on an outpatient basis;
4. It must admit and discharge patients from the facility within a 24-hour period;
5. It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an ambulatory surgical center as defined by those laws;
6. It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

**Appeal** means a review by the plan of an adverse benefit determination.
**Bariatric services** means the evaluation for bariatric surgery, the bariatric surgery and the post-discharge services and expenses related to complications following an approved bariatric surgery.

**Bariatric surgery** means gastrointestinal surgery to promote weight loss for the treatment of morbid obesity.

**Bariatric surgery treatment period** means six months from the date of discharge from the hospital following an approved bariatric surgery received while you were covered by this Plan.

**Behavioral health** means mental health services and substance abuse services.

**Beneficiary** means you and your covered dependent(s), or legal representative of either, and anyone to whom the rights of you or your covered dependent(s) may pass.

**Bodily injury** means bodily damage other than a sickness, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a sickness and not a bodily injury.
Calendar year means a period of time beginning on January 1 and ending on December 31.

Claimant means a covered person (or authorized representative) who files a claim.

Coinsurance means the shared financial responsibility for covered expenses between the covered person and this Plan, expressed as a percentage.

Complications of pregnancy means:
1. Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;
2. A nonelective cesarean section surgical procedure;
3. Terminated ectopic pregnancy; or
4. Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does not mean:
1. False labor;
2. Occasional spotting;
3. Prescribed rest during the period of pregnancy;
4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct complications of pregnancy; or
5. An elective cesarean section.

Concurrent review means the process of assessing the continuing medical necessity, appropriateness, or utility of additional days of hospital confinement, outpatient care, and other health care services.

Confinement or confined means you are admitted as a registered bed patient in a hospital or a qualified treatment facility as the result of a qualified practitioner’s recommendation. It does not mean detainment in observation status.
Copayment or co-pay, if applicable, means the specified dollar amount that you must pay to a provider for certain medical covered expenses regardless of any amounts that may be paid by this Plan as shown in the Schedule of Benefits section.

Cosmetic surgery means surgery performed to reshape structures of the body in order to change your appearance or improve self-esteem.

Court-ordered means involuntary placement in behavioral health treatment as a result of a judicial directive.

Covered expense means medically necessary services incurred by you or your covered dependents for which benefits may be available under this Plan, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of this Plan.

Covered person means the employee or any of the employee’s covered dependents enrolled for benefits provided under this Plan.

Creditable coverage means the total time of prior continuous health plan coverage periods used to reduce the length of any pre-existing condition limitation period applicable to you or your dependents under this Plan where these prior continuous health coverage(s) existed with no more than a 63-consecutive day lapse in coverage.

Custodial care means services provided to assist in the activities of daily living which are not likely to improve your condition. Examples include, but are not limited to, assistance with dressing, bathing, preparation and feeding of special diets, transferring, walking, taking medication, getting in and out bed and maintaining continence. These services are considered custodial care regardless if a qualified practitioner or provider has prescribed, recommended or performed the services.
**Deductible**, if applicable, means a specified dollar amount that must be satisfied, either individually or combined as a covered family, per calendar year before this Plan pays benefits for certain specified services.

**Dental injury** means an injury to a sound natural tooth caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided.

**Dependent** means a covered employee’s:

1. Legally recognized spouse;

2. Same sex domestic partner and their child(ren); domestic partners are individuals of the same gender, who live together in a long-term relationship of indefinite duration, with an exclusive mutual commitment in which the partners agree to be jointly responsible for each other’s common welfare and share financial obligations. The partners may not be related by blood to a degree of closeness which would prohibit legal marriage in the state in which they legally reside;

3. Common law spouse and their child(ren);

4. Your children, natural children, adopted children or children placed with you for adoption, stepchildren, children for whom you are the legal guardian, foster children or children for which the employee has legal guardianship and children of your domestic partner from birth to age 26;

Your child is covered to the limiting age regardless if the child is:

a. Married;

b. A tax dependent;

c. A student;

d. Employed; or

e. Residing with or receiving financial support from you; or

f. Eligible for coverage through employment

5. A covered employee’s child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order;
A covered child who attains the limiting age while covered under this Plan will remain eligible for benefits if all of the following exist at the same time:

1. Mentally retarded or permanently physically handicapped;

2. Incapable of self-sustaining employment;

3. The child meets all of the qualifications of a dependent as determined by the United States Internal Revenue Service;

4. Declared on and legally qualify as a dependent on the employee’s federal personal income tax return filed for each year of coverage; and

5. Unmarried.

You must furnish satisfactory proof to Aetna that the above conditions continuously exist on and after the date the limiting age is reached. Aetna may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to Aetna, the child’s coverage will not continue beyond the last date of eligibility.

**Diabetes equipment** means blood glucose monitors, including monitors designed to be used by blind individuals, insulin infusion pumps and associated accessories, insulin infusion devices and podiatric appliances for the prevention of complications associated with diabetes.

**Diabetes self-management training** means the training provided to a covered person after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of diabetes equipment and supplies. It also includes training when changes are required to the self-management regime and when new techniques and treatments are developed.

**Diabetes supplies** means test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes, prescriptive and nonprescriptive oral agents for controlling blood sugar levels, glucagons emergency kits and alcohol swabs.

**Durable medical equipment (DME)** means equipment that is medically necessary and able to withstand repeated use. It must also be primarily and customarily used to serve a medical purpose and not be generally useful to a person except for the treatment of a bodily injury or sickness.
Emergency means an acute, sudden onset of a sickness or bodily injury which is life threatening or will significantly worsen without immediate medical or surgical treatment.

Employee means you, as an employee, when you are permanently employed and paid a salary or earnings and are in an active status at your employer’s place of business.

Employer means the sponsor of this Group Plan or any subsidiary(s).

Expense incurred means the fee charged for services provided to you. The date a service is provided is the expense incurred date.

Experimental, investigational or for research purposes: A service is experimental, investigational or for research purposes if Aetna determines;

1. The service cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the service is furnished; or

2. The service or your informed consent document utilized with the service was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or

3. Reliable evidence shows that the service is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. Reliable evidence shows that the prevailing opinion among experts regarding the service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

5. Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same service; or the written informed consent used by the treating facility or by another facility studying substantially the same service.

External review: Means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to the federal external review
process or an applicable state external review process.

**Family member** means you or your spouse, or you or your spouse's child, brother, sister, parent, grandchild or grandparent.

**Functional impairment** means a direct and measurable reduction in physical performance of an organ or body part.

**Final external review decision** means a determination by an independent review organization at the conclusion of an external review.

**Final internal adverse benefit determination** means an adverse benefit determination that has been upheld by the Plan at the completion of the internal appeals process.
**Hospital** means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;

2. Has a physician and surgeon in regular attendance;

3. Provides continuous 24 hour a day nursing services;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;

5. Is legally operated in the jurisdiction where located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical services with an institution having a valid license to provide such surgical services; or

7. Is a lawfully operated qualified treatment facility certified by the First Church of Christ Scientist, Boston, Massachusetts.

Hospital does not include an institution that is principally a rest home, skilled nursing facility, convalescent home or home for the aged. Hospital does not include a place principally for the treatment of mental health or substance abuse.
**In-network provider** means a hospital, qualified treatment facility, qualified practitioner or any other health services provider who has entered into an agreement with, or has been designated by, Aetna to provide specified services to all covered persons.

**Independent review organization (or IRO)** means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations.
**Maintenance care** means any service or activity which seeks to prevent bodily injury or sickness, prolong life, promote health or prevent deterioration of a covered person who has reached the maximum level of improvement or whose condition is resolved or stable.

**Maximum allowable fee for a service** means the lesser of:

1. The fee most often charged in the geographical area where the service was performed;
2. The fee most often charged by the provider;
3. The fee which is recognized as reasonable by a prudent person;
4. The fee determined by comparing charges for similar services to a national data base adjusted to the geographical area where the services or procedures were performed; or
5. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed.

**Maximum benefit** means the maximum amount that may be payable for each covered person, for expense incurred. The applicable maximum benefit is shown in the Schedule of Benefits section. No further benefits are payable for the plan year once the maximum benefit is reached.

**Medically necessary or medical necessity** means the extent of services required to diagnose or treat a bodily injury or sickness which is known to be safe and effective by the majority of qualified practitioners who are licensed to diagnose or treat that bodily injury or sickness. Such services must be:

1. Performed in the least costly setting required by your condition;
2. Not provided primarily for the convenience of the patient or the qualified practitioner;
3. Appropriate for and consistent with your symptoms or diagnosis of the sickness or bodily injury under treatment;
4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for your symptoms, diagnosis, sickness or bodily injury; and
5. Substantiated by the records and documentation maintained by the provider of service.

**Medicare** means a program of medical insurance for the aged and disabled, as established under Title 18 of the Social Security Act of 1965, as amended.

**Mental health** means a mental, nervous, or emotional disease or disorder of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders, regardless of the cause or causes of the disease or disorder.

**Morbid obesity (clinically severe obesity)** means a body mass index (BMI) as determined by a qualified practitioner as of the date of service of:

1. 40 kilograms or greater per meter squared (kg/m²); or

2. 35 kilograms or greater per meter squared (kg/m²) with an associated comorbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions; or joint disease that is treatable, if not for the obesity.
Orthotic means a custom-fitted or custom-made braces, splints, casts, supports and other devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body when prescribed by a qualified practitioner.

Out-of network provider means a hospital, qualified treatment facility, qualified practitioner or any other health services provider who has not entered into an agreement with the Plan Manager to provide participating provider services or has not been designated by the Plan Manager as a participating provider.

Out-of-pocket limit, if applicable, is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per calendar year before a benefit percentage will be increased.
Partial hospitalization means services provided by a hospital or qualified treatment facility in which patients do not reside for a full 24-hour period:

1. For a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week;

2. That provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and

3. That has physicians and appropriately licensed mental health and substance abuse practitioners readily available for the emergent and urgent care needs of the patients.

The partial hospitalization program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered to be partial hospitalization services.

Partial hospitalization does not include services that are for custodial care or day care.

Pharmacist means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

Pharmacy means a licensed establishment where prescription medications are dispensed by a pharmacist.

Plan administrator or plan sponsor means the Manpower Companies.

Plan year means a period of time beginning on the Plan anniversary date of any year and ending on the day before the same date of the succeeding year.

Post-service claim means any claim for a benefit under a group health plan that is not a pre-service claim.

Preadmission testing means only those outpatient x-ray and laboratory tests made within seven days before admission as a registered bed patient in a hospital. The tests must be for the same bodily injury or sickness causing the patient to be hospital confined. The tests must be accepted by the hospital in lieu of like tests made during
confinement. Preadmission testing does not mean tests for a routine physical check-up.

**Precertification** means the process of assessing the medical necessity, appropriateness, or utility of proposed non-emergency hospital admissions, surgical procedures, outpatient care, and other health care services.

**Predetermination of benefits** means a review by Aetna of a qualified practitioner's treatment plan, specific diagnostic and procedure codes and expected charges prior to the rendering of services.

**Prescription** means a direct order for the preparation and use of a drug, medicine or medication. The drug, medicine or medication must be obtainable only by prescription. The prescription must be given to a pharmacist verbally, electronically or in writing by a qualified practitioner for the benefit of and use by a covered person. The prescription must include at least:

1. The name and address of the covered person for whom the prescription is intended;

2. The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;

3. The date the prescription was prescribed; and

4. The name and address of the prescribing qualified practitioner.

**Pre-service claim** means a claim with respect to which the terms of the Plan condition receipt of a Plan benefit, in whole or in part, on approval of the benefit by Aetna in advance of obtaining medical care.

**Protected health information** means individually identifiable health information about a covered person, including: (a) patient records, which includes but is not limited to all health records, physician and provider notes and bills and claims with respect to a covered person; (b) patient information, which includes patient records and all written and oral information received about a covered person; and (c) any other individually identifiable health information about covered persons.
Qualified practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a bodily injury or sickness, and who provides services within the scope of that license.

Qualified treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.
Services means procedures, surgeries, examinations, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Sickness means a disturbance in function or structure of your body that causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of your body.

Sound natural tooth means a tooth that:
1. Is organic and formed by the natural development of the body (not manufactured);
2. Has not been extensively restored;
3. Has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than a whole natural tooth.

Substance abuse means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Summary Plan Description (SPD) means this document that outlines the benefits, provisions and limitations of this Plan.

Surgery means excision or incision of the skin or mucosal tissues, or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.
Total disability or totally disabled means:

1. During the first twelve months of disability you or your employed covered spouse are at all times prevented by bodily injury or sickness from performing each and every material duty of your respective job or occupation;

2. After the first twelve months, total disability or totally disabled means that you or your employed covered spouse are at all times prevented by bodily injury or sickness from engaging in any job or occupation for wage or profit for which you or your employed covered spouse are reasonably qualified by education, training or experience;

3. For a non-employed spouse or a child, total disability or totally disabled means the inability to perform the normal activities of a person of similar age and gender.

A totally disabled person also may not engage in any job or occupation for wage or profit.

Urgent care claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

2. In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or

3. Generally, whether a claim is a claim involving urgent care will be determined by the Plan Manager. However, any claim that a physician with knowledge of a claimant's medical condition determines is a "claim involving urgent care" will be treated as a “claim involving urgent care.”

Utilization review means the process of assessing the medical necessity, appropriateness, or utility of hospital admissions, surgical procedures, outpatient care, and other health care services. Utilization review includes precertification and concurrent review.
You and your means you as the employee and any of your covered dependents, unless otherwise indicated.