

Dow Jones & Company



The Managed Choice[®] Plan



Expanded Summary of Benefits

As of January 1, 2007



All Full-Time and Regular Part-Time Non-IAPE and Non-Tandem Employees

Expanded Summary of Benefits

What is Managed Choice®?

Managed Choice is a point of service (POS) managed care plan that allows you to receive care from a network of physicians, hospitals and other health care providers with payment at higher or "preferred" rates. Care must be provided or coordinated through a primary care physician (PCP) to receive the preferred rates. If you feel you need services provided outside the network, you may make that choice at any point in time that you need health care services. However, when you receive care outside of the network, covered services are paid at lower or "non-preferred" rates (generally 70% of "Reasonable and Customary" charges after an annual deductible of \$650).

Who is Eligible?

You are eligible for coverage under the Aetna Managed Choice Plan if you are a:

- ❖ Full-time non-union employee,
- ❖ Regular part-time non-union employee.

Your eligible dependents include:

- ❖ Your spouse, and/or
- ❖ Your dependent children from birth until the end of the month in which they reach age 23, provided they are legally residing with you and dependent on you for support.

Dependent children may be covered up to age 25 if they are attending an accredited school or college on a full-time basis, or –up to any age– if they are physically or mentally incapacitated.

- ❖ Your qualified domestic partner.

Dow Jones/Aetna Managed Choice Plan

How Managed Choice Works

When you enroll in the Managed Choice Plan, you must select a primary care physician (PCP) who provides or coordinates your care. If you need specialty care, the primary care physician will refer you to a specialist practicing within the Managed Choice network. Many medical services, such as office visits and routine exams, are covered at 100% with just a \$20 copayment. For other services, such as surgery, hospital, and lab and X-rays, the Plan pays 90%. There are no charges in excess of reasonable and customary limits when your primary care physician is involved in your medical care. Your primary care physician files claims and handles precertification for you.

The Primary Care Physician (PCP)

You must select a primary care physician for yourself and each covered family member. The PCP may be a family practitioner, general practitioner, internist, or pediatrician. Female participants have direct access to a network obstetrician/gynecologist for routine care, and may schedule appointments without a referral from their PCP. If you want to change your PCP, you may select another through Aetna DocFind[®], Aetna's online provider directory at www.aetna.com/docfind or contact Aetna Member Services at (800) 338-8047 to make a new selection at any time during the plan year. You will receive an updated ID card with the new PCP indicated on it.

Getting Specialty Care

If your PCP is unable to provide the care you need, he or she will refer you to a specialist within the Managed Choice network. As part of the referral process, your PCP requests certification from Aetna for your visits to the specialist. You, the specialist and the PCP will receive a Notice of Certification that specifies the treatment authorized and the length of that authorization. If the specialist requires visits or recommends services not certified by Aetna, the specialist must consult the PCP.

Expanded Summary of Benefits

Enrolling in the Plan

You may enroll in the plan:

- ❖ As a new employee by completing a Dow Jones enrollment form within 31 days of your eligibility date. If you do not enroll during that time, please contact the Dow Jones Employee Benefits department for other enrollment options.
- ❖ During the annual enrollment period (usually in November), you must enroll online through dowjones.net.

Pre-Existing Conditions

Pre-existing condition rules do not apply for Dow Jones employees and their eligible dependents. (For an exception regarding hospitalization, see the next section.)

Coverage Becomes Effective

For Employees

- ❖ New employees: Coverage becomes effective on the first day of the month following 30 days of employment, provided you have completed and returned your enrollment form. However, if you begin work on the first day of a month, your coverage will be effective on the first day of the following month.
- ❖ Annual Open Enrollment: Coverage becomes effective on January 1.

Dow Jones/Aetna Managed Choice Plan

For Dependents

- ❖ If you have enrolled your dependents in the Managed Choice Plan, their coverage will be effective on the same day as yours.
- ❖ New dependents should be added to your Managed Choice Plan within 31 days of the date they become eligible. Otherwise, please contact the Dow Jones Employee Benefits department for other options.

If a dependent is confined in a hospital on the date coverage should take effect, coverage will not begin until the dependent is released from the hospital.

Family Status Changes

Once you have enrolled in the Managed Choice Plan, you can make an enrollment change when you have an eligible change in family status.

The following events are eligible family status changes:

- ❖ You gain a dependent through marriage, birth, adoption, or legal guardianship;
- ❖ You lose a dependent through divorce, legal separation, death, or loss of dependent eligibility (examples: because of age or student status);
- ❖ Your spouse terminates employment, or you, your spouse, or a dependent child becomes ineligible for benefits under another plan; or
- ❖ Your spouse begins full-time employment.

Contact the Dow Jones Employee Benefits department within 31 days of a family status change for assistance.

Expanded Summary of Benefits

Your Health Plan ID Card

When you enroll in the Managed Choice Plan, each covered family member will receive an ID card indicating the name of their primary care physician.

The card also shows the Aetna Member Services number. Call Member Services anytime you need help with questions, claim problems, or to change your primary care physician designation.

Summary of Benefits

The following chart provides a summary of the benefits available through the Aetna Managed Choice Plan. For more information, contact Aetna Member Services at (800) 338-8047, or the Dow Jones Employee Benefits department at (800) 220-1716.

Dow Jones/Aetna Managed Choice Plan

Dow Jones & Company Aetna Managed Choice® Plan Summary of Benefits

As of January 1, 2007

PLAN FEATURES	Preferred Benefits For care provided or referred by your primary care physician	Non-Preferred Benefits For care NOT provided or referred by your primary care physician
DEDUCTIBLE Per calendar year; applies to all covered services	None	\$650 per individual
OUT-OF-POCKET LIMIT Coinsurance limit and deductible	\$2,000 per individual \$4,000 per family	\$6,500 per individual
LIFETIME MAXIMUM	Unlimited	Unlimited
PHYSICIAN SERVICES Except Mental Health/ Substance Abuse Office Visits Routine Physical Exams Periodic physical assess- ment age 13 and over; pediatric/adult immuni- zations; one routine exam per 24 months including immunizations	100% after \$20 copay 100% after \$20 copay	70% subject to deductible Not covered ¹
1. You must use network providers for this service.		

Expanded Summary of Benefits

PLAN FEATURES	Preferred Benefits For care provided or referred by your primary care physician	Non-Preferred Benefits For care NOT provided or referred by your primary care physician
<p>Well-Baby Care To 13th birthday. Birth to 12 months – seven well visits; 12 months to 24 months – two well visits; 24 months to 13th birthday – one well visit, every 12 months.</p>	100% after \$20 copay	Not covered ¹
<p>Gynecological Exam(s) One annual exam which includes a Pap smear, pelvic exam and breast exam. Office visits for <u>any</u> gynecological related problems. Follow-up care.</p>	100% after \$20 copay Direct access to a network OB/GYN provider. No referral needed from PCP.	Not covered ¹
<p>Routine Mammography One mammogram every two years, to age 40 One mammogram per calendar year, age 40+</p>	90%	70% subject to deductible
<p>Routine Eye Exam One exam per 12 months on a self-referral basis to a network ophthalmologist or (where available) optometrist</p>	100% after \$20 copay	Not covered ¹
<p>Lenses and Frames</p>	Available at discounted rates at participating retailers. See page 17.	Not covered ¹
<p>Routine Hearing Exam One exam per 24 months</p>	100% after \$20 copay (Hearing aids are not covered.)	Not covered ¹
<p>Specialists Office visits</p>	100% after \$20 copay	70% subject to deductible

1. You must use network providers for these services.

Dow Jones/Aetna Managed Choice Plan

PLAN FEATURES	Preferred Benefits	Non-Preferred Benefits
	For care provided or referred by your primary care physician	For care NOT provided or referred by your primary care physician
Surgery (including Oral Surgery)	90% No referral needed from PCP for oral surgery.	70% subject to deductible
Physician Hospital Services	90%	70% subject to deductible
Allergy Testing	100% after \$20 copay	70% subject to deductible
Allergy Treatment	90%	70% subject to deductible
Diagnostic X-Ray and Laboratory Except in physician's office when office visit copay applies	90%	70% subject to deductible
HOSPITAL SERVICES		
Inpatient Coverage	90%	70% subject to deductible; up to semi-private room rate
Outpatient Coverage	90%	70% subject to deductible
Emergency Room	100% after \$25 emergency room copay (Waived if the patient is confined.)	100% after \$25 emergency room deductible (Waived if the patient is confined.)
Non-Emergency Use of Emergency Room	Not covered	Not covered
OTHER COVERED SERVICES	(If precertified)	(If precertified)
Skilled Nursing Facility Care	90% up to 60 days per calendar year ²	70% subject to deductible; up to 60 days per calendar year ²

2. Maximums are combined for preferred and non-preferred services.

Expanded Summary of Benefits

PLAN FEATURES	Preferred Benefits For care provided or referred by your primary care physician	Non-Preferred Benefits For care NOT provided or referred by your primary care physician
<p>Home Health Care No prior hospital confinement required</p>	90% up to 120 visits per calendar year ²	70% subject to deductible; up to 120 visits per calendar year ²
<p>Chiropractic Care</p>	100% after a \$20 copay; up to 60 visits per calendar year, see page 18.	70% subject to deductible; up to 60 visits per calendar year, see page 18.
<p>Private Duty Nursing Care</p>	90% up to 70 eight-hour shifts per calendar year ²	70% subject to deductible; up to 70 eight-hour shifts per calendar year ²
<p>Hospice Care (Inpatient and Outpatient) Includes five bereavement sessions per calendar year</p>	90% ²	70% subject to deductible ²
<p>Ambulance Service If for emergency or if part of other precertified care</p>	90%	70% subject to deductible
<p>Prescription Drug If a member chooses a brand-name drug, the plan pays generic level only and member pays the difference plus the applicable copay</p>		
<p>In Hospital</p>	90%	70% subject to deductible
<p>Pharmacy</p>	100% for a generic drug after \$10 copay; \$20 copay for a brand-name formulary drug; \$40 copay for a brand-name non-formulary drug; for up to a 30-day supply at participating pharmacies. See page 19.	70% subject to deductible

2. Maximums are combined for preferred and non-preferred services.

Dow Jones/Aetna Managed Choice Plan

PLAN FEATURES	Preferred Benefits	Non-Preferred Benefits
	For care provided or referred by your primary care physician	For care NOT provided or referred by your primary care physician
Mail Order (Aetna Rx Home Delivery)	100% after a \$20; \$40; or \$80 copay; up to a 90-day supply	Not covered
Durable Medical Equipment	90%	70% subject to deductible
Physical, Occupational, Speech Therapy	90% up to 60 visits per calendar year ² , see page 18.	70% subject to deductible; up to 60 visits per calendar year ² , see page 18.
Maternity Care/ Obstetrician Expenses	100% after \$20 copay for initial office visit; thereafter 90%	70% subject to deductible
Tubal Ligation and Vasectomy	Payable same as any other covered preferred expense	Payable same as any other covered non-preferred expense
MENTAL HEALTH SERVICES ³		
Inpatient Coverage	90% up to calendar year maximum of 30 days ⁴	70% subject to deductible; up to calendar year maximum of 30 days ⁴
Outpatient Coverage	100% after \$25 copay; up to calendar year maximum of 20 visits ⁴	50% subject to deductible; \$60 per visit maximum benefit, up to calendar year maximum of 20 visits ⁴
Calendar Year Maximum	None	None
ALCOHOL/DRUG ABUSE TREATMENTS³		
Lifetime Maximum	Two treatments ⁴	Two treatments ⁴
Calendar Year Maximum	\$100,000 ²	\$100,000 ²
<p>2. Maximums are combined for preferred and non-preferred services.</p> <p>3. To access Mental Health and Substance Abuse benefits, call (800) 424-4047 to register.</p> <p>4. Combined Mental Health and Alcohol/Drug Abuse maximum for preferred and non-preferred services.</p>		

Expanded Summary of Benefits

Coinsurance limits, where included, apply per individual on a calendar year basis. Only those out-of-pocket expenses resulting from the application of a deductible and coinsurance percentage may be used to satisfy the coinsurance limit. Mental health and substance abuse expenses, copays, outpatient prescription drug expenses, and penalties are excluded from the coinsurance limit.

Coverage maximums up to a certain number of days/visits per calendar year are reached by combining either preferred or non-preferred benefits up to the limit for one or the other, but not both. (Example: if preferred benefit is for 60 days and non-preferred benefit is for 60 days, the maximum benefit is 60 days, not 120 days).

Precertification applies to inpatient hospital services, treatment facility charges for alcohol/drug abuse, skilled nursing facility, home health care, private duty nursing, hospice care and certain ambulatory procedures. For PCP performed/referred services, the provider initiates precertification; there is no penalty for failure to precertify. For self-referred services, the employee must precertify care; there is a \$400 penalty per occurrence for failure to precertify inpatient admissions and a \$200 penalty per occurrence for failure to precertify certain procedures and tests. For a complete list of services which require precertification, see page 14.

You may use your MedSpend Account to reimburse yourself for out-of-pocket expenses not covered by the medical plans. You may contribute up to \$5,000 each year in pre-tax dollars and apply your contribution to non-covered medical plan expenses, such as deductibles, copays, and coinsurance expenses.

*This is only a brief summary of the preferred and non-preferred benefits available through Managed Choice. Some restrictions may apply. For more specific information about the coverage details, **including limitations, exclusions and other plan requirements**, see the rest of this booklet. You may also contact the Dow Jones Employee Benefits department at (800) 220-1716, or call Aetna Member Services at (800) 338-8047.*

Dow Jones/Aetna Managed Choice Plan

Important Terms Under the Managed Choice Plan

❖ Coinsurance

The portion of a covered expense you have to pay when care is not provided or coordinated through the PCP. For example, if the Plan covers services at 90%, you must pay 10% of the charge for the service.

❖ Copayment (or Copay)

The flat fee you pay for certain services provided or coordinated through your PCP, such as the \$20 fee for physician office visits. The Plan pays the rest of the covered expense at 100%, with no deductible required. Copays of \$10, \$20, or \$40 for retail pharmacy drugs and \$20, 40 or \$80 for mail-order pharmacy drugs also apply to prescription drug coverage through the Aetna Pharmacy Management Program.

❖ Deductible

The amount you have to pay toward covered services each calendar year before the Plan begins to pay benefits. There is no deductible required at the “preferred” level of benefits.

❖ Formulary

The formulary is a list of preferred generic and brand-name drugs approved by the FDA. In general, you’ll pay less out of pocket for drugs that are on the formulary. You can view Aetna’s formulary list at www.aetna.com/formulary. You’ll see that drugs are listed by condition or use. If you have questions about the Aetna formulary, you can call Aetna Member Services at 1-800-338-8047.

❖ Medically Necessary

The Plan only pays benefits for services and supplies which are appropriate for the diagnosis, care or treatment of the disease or injury involved.

❖ Out-of-Pocket Maximum

The most you have to pay in deductible and coinsurance expenses during a calendar year. The Plan then pays 100% of the cost of any remaining expenses for the rest of the calendar year. Prescription drug expenses and mental health and alcohol/drug abuse charges do not count toward the out-of-pocket maximum.

Expanded Summary of Benefits

❖ Reasonable and Customary

The Managed Choice Plan will only pay up to the reasonable and customary cost of a service/supply when your care is not provided or coordinated by your PCP. The reasonable and customary cost is the lower of the provider's usual cost for performing the service, or the charge Aetna determines to be the prevailing charge made for it in the geographic area where it is provided.

Precertification

Precertification is a process that determines whether or not an inpatient stay and certain surgical procedures are medically necessary and appropriate for your care. It is also the basis for determining whether the anticipated length of an inpatient stay is appropriate for your condition.

How to Precertify Care

Precertification starts with a call to Aetna Member Services at (800) 338-8047. Here are the guidelines to remember:

- ❖ If care is provided or referred by your primary care physician, he or she will handle all precertification requirements for you.**
- ❖ If care is provided by a physician or facility outside of the Managed Choice network, YOU MUST PRECERTIFY CARE. If you fail to precertify care when required, there is a \$400 penalty for inpatient admissions and \$200 penalty for certain procedures and tests per occurrence.**

When to Precertify Care

- ❖ 14 days before a scheduled facility admission.**
- ❖ 14 days before treatments, procedures or tests, as listed.**
- ❖ 48 hours after an emergency admission or procedure.**

Dow Jones/Aetna Managed Choice Plan

What to Precertify

The following types of medical care and surgical treatments must be precertified whenever care is not provided or referred by your primary care physician. See page 11 for the penalty amount you must pay if you fail to precertify.

- ❖ All non-emergency inpatient hospital admissions.
- ❖ Treatment in skilled nursing and rehabilitation facilities.
- ❖ Care from home health agencies, private duty nurses, and hospices.
- ❖ Certain tests and procedures must be precertified, including the following:
 - ◆ **Allergy Immunotherapy** – treatment of allergies by injections.
 - ◆ **Bunionectomy** – removal of bunions.
 - ◆ **Carpal Tunnel Surgery** – surgery of the wrist nerve.
 - ◆ **Colonoscopy** – scope examination of large intestine.
 - ◆ **Coronary Angiography** – X-ray, picture, or visualization of dye injected into the arteries of the heart and/or heart chambers.
 - ◆ **CT Scan-Spine** – computerized X-ray of the spine.
 - ◆ **Dilation & Curettage (D&C)** – examination of the cervix and removal of tissue from the lining of the uterus for examination.
 - ◆ **Hemorrhoidectomy** – removal of hemorrhoids.
 - ◆ **Knee Arthroscopy** – scope in knee joint for diagnosis and/or treatment.
 - ◆ **Laparoscopy** – scope examination of the pelvis.
 - ◆ **MRI-Knee** – study of the knee using magnetic technology.
 - ◆ **MRI-Spine** – study of the spine using magnetic technology.
 - ◆ **Septoplasty** – nose surgery for functional improvement.
 - ◆ **Tympanostomy** – insertion of tubes into ears.
 - ◆ **Upper Gastro-Intestinal Endoscopy** – scope examination of the esophagus, stomach and small intestine.

Expanded Summary of Benefits

What Happens When You Precertify

When you call Aetna Member Services, the nurse consultant will ask for some basic information:

- ❖ Your name and the patient's name (if a dependent).
- ❖ The condition being treated.
- ❖ Your doctor's name, address and phone number.
- ❖ The hospital's name, address and phone number.
- ❖ The scheduled date of admission.

If necessary, the nurse will contact the doctor for more information. You and your physician will be notified by mail of the certification decision. The Notice of Certification will indicate the number of days certified. If the inpatient stay lasts longer than that, you must call Aetna Member Services to certify the extra days no later than the last day of certified care.

Dow Jones/Aetna Managed Choice Plan

Emergency Care and Urgent Care Information

There are two types of situations that require prompt medical attention: “emergency care” and “urgent care.” Be sure to understand what to do in these situations, so you can get the best care and treatment and receive the appropriate coverage.

Emergency Care

Emergency care for a life-threatening or severe medical condition is always covered, 24 hours a day, seven days a week, no matter where you are. An emergency is a serious accident or a sudden onset of an illness or medical condition which manifests itself by acute symptoms, including severe pain, and which is severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- ❖ The patient’s health would be placed in serious jeopardy.
- ❖ A bodily function would be seriously impaired.
- ❖ There would be a serious dysfunction of a bodily organ or part.

Examples of a Medical Emergency

- ❖ Uncontrolled bleeding
- ❖ Severe shortness of breath
- ❖ Loss of consciousness
- ❖ Suspected overdose of medication
- ❖ Poisoning
- ❖ Suspected stroke or heart attack

Expanded Summary of Benefits

If you have an emergency, you should go immediately to the nearest hospital emergency room or urgent care center, whether or not it is a preferred facility. You or someone on your behalf should then contact your PCP or Aetna Member Services at (800) 338-8047 within 48 hours of being treated.

If the phone call is made in a timely manner and the emergency room setting is considered appropriate, the charges will be paid as a preferred benefit. After a \$25 copayment, you're covered at 100%. If you are admitted to the hospital through the emergency room, the \$25 copayment will be waived.

If the emergency results in hospitalization, you or someone on your behalf should call your PCP within two business days to receive "preferred" benefits.

If no phone call is made, you will be covered on a non-preferred basis, regardless of whether or not you are hospitalized in a preferred hospital.

If you are hospitalized in a non-preferred hospital as a result of the emergency, and you comply with plan requirements, you will be covered at the preferred level if Aetna's medical management determines that a move to a preferred facility would be medically inadvisable or impractical. Otherwise, your hospital expenses will be paid at the non-preferred level.

If the emergency room is not considered appropriate for the treatment of your illness or injury, no coverage will be provided.

Urgent Care

Some situations, although not life-threatening or serious, still require immediate medical attention. Some examples of urgent care situations are: ear infections, sprains, urinary tract infections, vomiting, high fever, or minor burns. In these non-life-threatening situations, call your primary care physician or Aetna Member Services for advice on obtaining preferred medical care services.

Vision One

The Vision One program provides discounts on eye care needs, including frames, lenses and contacts. Discounts are available at over 2,500 locations nationwide. Convenient locations include optical centers in stores such as Sears, JC Penney, Target, many of the Pearle Vision Centers and at selected independent doctor's offices. Present your Dow Jones/Aetna Managed Choice Plan card at time of purchase.

Dow Jones/Aetna Managed Choice Plan

Physical, Occupational, and Speech Therapy Coverage

Physical and Occupational Therapy is medically necessary treatment by a physiotherapist or an occupational therapist. Medically necessary treatment is limited to services which restore function or maximize abilities limited by (1) an accident or illness, or (2) developmental disabilities* in children under age ten.

This provision does not cover charges for (a) educational therapy, or (b) services that are not directly related to the therapy necessary to restore function or maximize abilities due to an accident, illness, or developmental disability (see page 23 for additional information).

Speech Therapy by a qualified speech therapist is covered if required to:

- ❖ Restore speech loss or impairment after a previous ability to speak.
- ❖ Develop or improve speech after surgery to correct a birth defect which impairs, or would have impaired, the ability to speak (if the condition cannot be surgically corrected, benefits will be paid even if surgery has not been performed).
- ❖ Correct developmental disabilities* in children under age ten that are directly related to an illness that caused an impairment or delay in speech development. This provision does not include charges for (a) educational therapy, or (b) developmental services that are not directly related to the therapy necessary to assist in the development of speech. Chiropractic Care
- ❖ The Plan covers up to 60 visits per calendar year for the treatment of a medical condition, provided the care is medically necessary and appropriate for the condition, and falls within the scope of the provider's license. Treatments to maintain a condition or that are palliative (relieve pain) in nature are not covered (see page 23 for additional information).

* ***Developmental disabilities relate to conditions for which an individual's growth and development fail to progress along accepted norms because of genetic, physical, or psychological factors. They include, but are not limited to, all of the following: attention deficit disorders, hyperactivity, expressive language disorder, dyslexia, growth delay, speech delay, stuttering, and articulation disorder.***

Expanded Summary of Benefits

Your Prescription Drug Coverage

Coverage under the Managed Choice Plan is provided through two Aetna Pharmacy Management programs:

- ❖ A participating pharmacy program, and
- ❖ A mail order drug program.

The Participating Pharmacy Program

Preferred coverage for prescription drugs depends on whether or not you use a pharmacy that participates in the Aetna Pharmacy Management Program.

When you use a participating pharmacy, you are covered 100% for up to a 30-day supply of medication after meeting a copayment. You will pay \$10 for generic drugs; and \$20 for brand-name formulary drugs; and \$40 for brand-name non-formulary drugs. Please note, if you elect a brand-name medication when a generic equivalent is available, the Managed Choice plan pays at the generic level only and you will pay the difference plus the brand-name copayment. Some limitations may apply to the amount of medication a participating pharmacy may dispense, regardless of the doctor's prescription.

A preferred drug list or formulary is a list of generic and brand name prescription medications that have been approved by the FDA as safe and effective. A preferred drug list helps provide access to quality, affordable prescription drug benefits. The drugs listed on the preferred drug list either represent an important therapeutic advance, or are clinically equivalent and possibly more cost effective than other drugs not on the preferred drug list. You can review Aetna's formulary list at www.aetna.com/formulary or by calling Aetna Member Services at (800) 338-8047.

Drugs prescribed by a mental health provider on an outpatient basis are covered under the medical program and may be purchased at a participating pharmacy. If you go to a non-participating pharmacy, submit your claims to Aetna. Drugs prescribed on an inpatient basis will generally be covered by the Mental Health/Alcohol and Drug Abuse program.

Dow Jones/Aetna Managed Choice Plan

Covered Prescriptions

Generally, drugs and supplies are covered if they are approved by the FDA, prescribed by a doctor or other recognized practitioner (such as a dentist), and approved by Aetna as medically necessary. The following is a partial list of prescription drugs and supplies covered by the program:

- ❖ AZT
- ❖ Compound drugs – drugs that have more than one ingredient, one of which requires a prescription
- ❖ Federal legend drugs – require a label, “Caution: Federal law prohibits dispensing without a prescription”
- ❖ Fertility medications (up to six cycles)
- ❖ Diabetes testing supplies (tabs, tapes and strips) with a prescription
- ❖ Oral contraceptives and devices (preferred benefits only). Refer to the Summary of Benefits Chart for more information.
- ❖ Injectables
- ❖ Insulin, with a prescription
- ❖ Lancets, with a prescription
- ❖ Needles and syringes
- ❖ Pre-natal vitamins
- ❖ Smoking cessation products (Nicorette gum and Transdermal patches)
- ❖ Vitamins with fluoride (for children under 12)

Expanded Summary of Benefits

The Mail Order Program

The Mail Order Program is available through Aetna Rx Home Delivery. It is an effective way of obtaining maintenance drugs used on a regular basis. These are prescription medications taken for conditions such as diabetes, high blood pressure, estrogen deficiency, or heart conditions and are prescribed by physicians, usually in a 90-day supply.

In addition to the convenience of having medications mailed directly to your home, you save money with this program, too. A 90-day supply may be ordered with a \$20 copayment for a generic drug; \$40 for a brand-name formulary drug; and \$80 for a brand-name non-formulary drug.

Medications NOT Covered by the Aetna Pharmacy Management Program

The following is a partial list of items **not** covered under the Program, and that do not qualify for reimbursement:

- ❖ Appetite suppressants
- ❖ Certain dietary supplements
- ❖ Vitamins (this exclusion does not apply to pre-natal vitamins or vitamin supplements containing fluoride for children under 12)
- ❖ Vitamin supplements
- ❖ Rogaine and other hair growth medications
- ❖ Over the counter/non-prescription medications
- ❖ Special baby formulas
- ❖ Erectile dysfunction

Dow Jones/Aetna Managed Choice Plan

Excluded Medical Services

Like all medical benefit plans, there are certain services that do not qualify for reimbursement under the hospital or medical coverages of the Managed Choice Plan:

- ❖ Acupuncture, except when used in lieu of anesthesia.
- ❖ Charges for non-preferred services in excess of usual and customary levels, determined in accordance with general industry practices.
- ❖ Cosmetic Surgery – Surgery performed mainly to change a person’s appearance. It includes surgery performed to treat a mental, psychoneurotic, or personality disorder through change in appearance. Cosmetic surgery is covered when it is reconstructive surgery, as follows:
 - ◆ In connection with surgery resulting from trauma, infection, or disease of the involved part, or
 - ◆ Due to a birth disease or defect which impairs the function of a body organ.
- ❖ Custodial Care.
- ❖ Dental Charges, including X-ray exams. This applies even if a condition requiring dental services involves a part of the body other than the mouth, such as the treatment of Temporomandibular Joint Disorders (TMJ) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring, or repositioning teeth. Dental services are covered under the Dow Jones Dental Care Program.
- ❖ Drugs or methods of treatment not approved by the Food and Drug Administration (FDA), the American Medical Association or the appropriate medical specialty society, or considered to be experimental or investigational in nature. A service or supply is considered experimental or investigational if Aetna determines that:
 - ◆ The service or supply is under study or clinical trial to evaluate its toxicity, safety, or efficacy for a particular use.
 - ◆ The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation.
 - ◆ In the case of a drug or other supply that is subject to FDA approval, it has approval only for investigational purposes.

Expanded Summary of Benefits

Excluded Medical Services (continued)

- ❖ Educational services or supplies. Educational means that the primary purpose is to provide training in activities of daily living (beyond the training related to restoration of function lost to a specific sickness or injury), instruction in scholastic skills, treatment for learning disabilities, or preparation for an occupation.
- ❖ Education, training, and bed and board while confined to an institution that is mainly a school or other institution for training, a place of rest, a place for the aged, or a nursing home.
- ❖ Expenses incurred before you or your dependents become covered, or after coverage ends.
- ❖ Eyeglasses, hearing aids, and other devices unless the charges result from an accident which happens while you or your dependents are covered by the plan.
- ❖ In-vitro fertilization procedures. (However, lab tests and diagnostic procedures to determine the cause of infertility are covered by the plan.)
- ❖ Mental Health/Substance Abuse services above the maximums provided as part of this plan.
- ❖ Non-preferred routine newborn well-baby care, except for hospital charges for nursery care.
- ❖ Physical or occupational therapy or chiropractic care that is maintenance in nature and not for treatment of sickness or injury. For example, visits to a chiropractor for routine adjustments are not covered.
- ❖ Private duty nursing for an inpatient in a hospital.
- ❖ Providers rendering services outside the scope of their licenses.
- ❖ Radial keratotomy.
- ❖ Reversals of tubal ligation and sterilizations.

Dow Jones/Aetna Managed Choice Plan

Excluded Medical Services (continued)

- ❖ Routine checkups or physical exams (except for mammograms), not related to the diagnosis of an illness or injury, except when provided on a preferred basis.
- ❖ Routine foot care, including removal of corns, calluses, or toe-nails. (Foot care that is a result of a disease or injury, such as infected corns, would be covered under the Managed Choice Plan.)
- ❖ Services furnished for, or by, the U.S. Government or any other government, that result in no charge for the treatment provided.
- ❖ Services and supplies not prescribed by the attending physician.
- ❖ Services or supplies not medically necessary.
- ❖ Services provided at no cost.
- ❖ Services received as a result of a legal action or settlement. (For additional information, please see the section in the Dow Jones employee benefits booklet entitled, "Subrogation and Reimbursement.")
- ❖ Services provided by an immediate family member – spouse, parents, grandparents, child, and siblings of the employee or dependents.
- ❖ Treatment resulting from an occupational accident or illness that is covered by Workers' Compensation or similar legislation.

Expanded Summary of Benefits

Call Aetna Member Services for Information

Whenever you need quick, accurate answers to health-related questions, call Aetna Member Services at (800) 338-8047. Aetna Member Services can help you with questions about your coverage, the status of a claim, precertification of care delivered outside the Managed Choice network, and making changes to your PCP designation.

Filing Claims

If your care is provided or coordinated by your PCP, he or she will file claims for you. Otherwise, you must file claims with Aetna for reimbursement of covered services. Claims should be filed within 90 days, but not more than two years, from the date the service was provided.

Each time either you, or your PCP, files a medical claim with Aetna, you will receive an Explanation of Benefits (EOB) statement explaining how the benefit payment was calculated, whether further information is needed to complete the processing of the claim, and where to call if you have questions.

Keep this statement as your record of expenses for income tax purposes. Copies are not available.

Dow Jones/Aetna Managed Choice Plan

Claim Review and Appeals

Benefits may be reduced if the expense of a treatment exceeds the reasonable and customary charge for it, or if you failed to precertify an admission or procedure when it was required. Benefits may be denied if Aetna believes the procedure is not medically necessary or not appropriate for the condition being treated; for example, if the normal stay in a hospital is three days and you remain for six.

To appeal a reduction or denial of benefits, you must state your concerns in writing. Direct your written request for appeal to Aetna Member Services within 60 days:

Aetna Inc.
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512

Depending on the reason for the appeal, Aetna's review may involve claim administrators, nurse consultant supervisors, and physicians. You will be notified of Aetna's decision in writing, usually within 60 days from the date your appeal is received. In no case will the appeal decision take longer than 120 days from the date your appeal is received.

If certification is denied and you decide to go ahead with the admission or procedure, you may submit your claim with additional supporting information for Aetna to retrospectively review.

For more information, contact the Dow Jones Employee Benefits department.

Expanded Summary of Benefits

How Benefits Are Coordinated With Other Plans

If you, your spouse, and/or your covered dependents have coverage under more than one health benefits plan, payment for covered services will be coordinated among the two plans. The Coordination of Benefits provision assures that your expenses are paid, but that the combined payments from all plans do not amount to more than the amount you could have received from the Managed Choice Plan alone.

For example, if a person is covered as an employee under the Dow Jones plan and as a dependent under another health plan, the plan of the employee would pay benefits first. In this case, the employee would submit the claim to Aetna for the Dow Jones plan. Any unpaid balance would then be submitted to the plan covering the person as a dependent.

If Your Health Care Coverage Ends

If your coverage under the Plan ends because of:

- ❖ termination of your employment for any reason other than gross misconduct, or
- ❖ your loss of eligibility under this Plan due to a reduction in the number of hours you work,

you may apply for continuation coverage for yourself and your dependents, or your dependents may elect to continue their own coverage. You must apply for continuation coverage within 60 days, and must agree to pay any required contributions. Generally, coverage is available for up to 18 months from the date of the event that terminated coverage.

Dow Jones/Aetna Managed Choice Plan

If coverage for a dependent terminates due to one of these events:

- ❖ your death,
- ❖ your divorce,
- ❖ you stop making required contributions for coverage for a spouse from whom you are legally separated,
- ❖ a dependent child reaches the age limit for coverage,
- ❖ dependent coverage ends because they are eligible for Medicare, or
- ❖ your domestic partner fails to meet all defined requirements,

the dependent may elect to continue coverage within 60 days, and must agree to pay any required contributions. Generally, coverage is available for up to 36 months from the date of the event that terminated coverage.

Coverage for surviving dependents will be continued for six (6) months on a non-contributory basis. Otherwise, you are required to pay the full cost of continued coverage plus an administrative fee.

You may also apply to convert your group insurance coverage to an individual policy. Contact the Dow Jones Employee Benefits department for more information.

Expanded Summary of Benefits

If You Are Changing to the Managed Choice Plan

Here are some common transition situations that can affect your coverage. Please contact the Dow Jones Employee Benefits department if you have questions, or a situation that is not covered here.

- ❖ If you are enrolled in the Managed Choice Plan, but are confined in a hospital or an extended care facility when coverage becomes effective, benefits will be paid to the hospital or extended care facility under the terms of the prior plan.
- ❖ If you are enrolled in the Managed Choice Plan, but are undergoing an active course of treatment that was started under your prior plan (for example, post-operative care or post-application of a cast), benefits for that course of treatment will be paid under the terms of the prior plan.
- ❖ If you are pregnant and receiving prenatal care, benefits will be paid as follows:
 - ❖ Hospital room and board and associated fees (including your obstetrician) will be paid under the terms of the prior plan.
 - ❖ Physician services for the newborn will be paid under the Managed Choice Plan, based on whether or not the physician is a primary care physician or has been referred by the PCP.
 - ❖ If you are covering a dependent who is away at school, the dependent should select a PCP from your local network area. While at school, it is expected that medical care will be received through student health services. If more extensive care is required, it should be coordinated or referred through the PCP. Emergency care will be reimbursed at the preferred level regardless of where it is provided.

Dow Jones/Aetna Managed Choice Plan

Health Care Information

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

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

For More Information

This booklet contains a summary of the features and benefits of the Aetna Managed Choice Plan. Please review the information so you can use the program wisely. Your eligibility or your right to benefits should not be interpreted as a guarantee of employment. This booklet is considered to be part of the Summary Plan Description (SPD) for the Dow Jones & Company Health Care Plan and is incorporated into that SPD. The benefits described under the Managed Choice Option are distinct from the benefits provided by the Dow Jones/Aetna Open Choice PPO Option. The Managed Choice program's governance and administration – including eligibility, COBRA, claims appeal, subrogation and reimbursement procedures, and ERISA rights – are described in the SPD covering all Dow Jones benefit plans and programs. For more information, contact the Dow Jones Employee Benefits department at (800) 220-1716, or in South Brunswick, NJ at (609) 520-4185.