

**Middlesex County Joint Health Insurance Fund**

**Aetna HMO Plan**

**Middlesex County Retiree**

**Middlesex County Administration**

**Middlesex County Board of Social Services**

**Middlesex County Roosevelt Hospital**

***Welcome!***

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

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

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

***We wish you the best of health.***

*\* As used in this booklet, “HMO” refers to HMO-type benefits that are self-funded by your employer.*

## **How to Use Your Plan Description**

This booklet is your guide to the benefits available through your employer's HMO Plan. Please read it carefully and refer to it when you need information about how the Plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about many of the special programs available to you as a Plan participant.

If you cannot find the answer to your question(s) in the booklet, call the Member Services toll-free number on your ID card. A trained representative will be happy to help you. For more information, go to the "Member Services" section later in this book.

### ***Tips for New Plan Participants***

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

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# How the Plan Works

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

Each participant in the Plan must select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system and will help you access appropriate care.

## The Primary Care Physician

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

Participating specialists are required to send reports back to your PCP to keep your PCP informed of any treatment plans ordered by the specialist.

## Primary and Preventive Care

Your PCP can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP. You may also obtain routine vision exams, and gynecological exams from participating providers without a referral from your PCP. You are responsible for the copayment shown in the "Summary of Benefits."

## Specialty and Facility Care

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

When your PCP refers you to a participating specialist or facility for covered services, you will be responsible for the copayment shown in the "Summary of Benefits."

To avoid costly and unnecessary bills, follow these steps:

- **Consult your PCP first** when you need routine medical care. If your PCP deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. Referrals are valid for 90 days, as long as you remain an eligible participant in the Plan. For direct access benefits, you may contact the participating provider directly, without a referral.
- Certain services require **both** a referral from your PCP **and** prior authorization from Aetna. Your PCP is responsible for obtaining authorization from Aetna for in-network covered services.
- **Review the referral** with your PCP. Understand what specialist services are being recommended and why.
- Present the referral to the participating provider. Except for direct access benefits, any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services.**
- If it is not an emergency and you go to a doctor or facility **without your PCP's prior written or electronic referral, you must pay the bill yourself.**
- Your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by Aetna in addition to a special nonparticipating referral from your PCP. When properly authorized, these services are covered after the applicable copayment.

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

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

## **Provider Information**

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

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

## **Your ID Card**

When you join the Plan, you and each enrolled member of your family receive a member ID card. Your ID card lists the telephone number of the Aetna PCP you have chosen. If you change your PCP, you will automatically receive a new card displaying the change.

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



# Summary of Benefits

<b>Maximum Benefit</b>	Unlimited
<b>Primary and Preventive Care</b>	
PCP Office Visits	\$ 2 copay per visit
After Hours/Home Visits/Emergency Visits	\$ 5 copay per visit
Routine Examinations 1 visit per calendar year	\$ 2 copay per visit
Routine Child and Well-Baby Care	\$ 2 copay per visit
Immunizations	\$ 2 copay per visit
Routine Gynecological Exams - direct access (no referral) to participating providers for 1 visit per calendar year	\$ 2 copay per visit
Routine Mammogram - one annual mammogram for women age 40 and over	\$ 2 copay per visit
Prostate Screening - one annual prostate screening for men age 40 and over	\$ 2 copay per visit
Routine Eye Examinations - direct access (no referral) to participating providers for periodic routine exams	\$ 2 copay per visit
Eyeglasses/Contact Lenses	\$ 100 per 24-month period Discounts available through Vision One Discount Program
Hearing Exam by an Audiologist	\$ 2 copay per visit
Hearing Aids	Not covered
<b>Specialty and Outpatient Care</b>	
Specialist Office Visits	No copay
Specialist Care Provided Outside the Office	No copay
Prenatal Care - for the first OB visit	No copay
Infertility Services	No copay
Advanced Reproductive Technology	Copay based on where service is provided
Allergy Testing	No copay
Allergy Treatment	No copay
Routine injections at PCP's office, with or without physician encounter	
Outpatient Rehabilitation Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment	No copay

Outpatient Therapy (speech, occupational, physical) Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment	No copay
Chiropractic Care	No copay
Durable Medical Equipment (DME)	No copay
Prosthetic Devices	No copay - some prostheses must be approved in advance by Aetna
<b>Inpatient Services</b>	
Hospital Room and Board and Other Inpatient Services	No copay
<b>Surgery and Anesthesia</b>	
Inpatient Surgery	No copay
Outpatient Surgery	No copay
<b>Mental and Nervous Conditions</b>	
Inpatient Treatment  Maximum of 35 days per calendar year	No copay
Outpatient Treatment  30 visits per calendar year	\$ 10 copay
<b>Treatment of Alcohol and Drug Abuse</b>	
Inpatient Detoxification	No copay
Inpatient Rehabilitation Maximum of 28 days per calendar year	No copay
Outpatient Rehabilitation 30 visits per calendar year	No copay
<b>Emergency Care</b>	
Hospital Emergency Room or Outpatient Department	\$ 15

# Your Benefits

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

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

## Primary and Preventive Care

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

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your PCP.
- Well-child care from birth, including immunizations and booster doses, as recommended by your PCP.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Routine gynecological examinations and Pap smears performed by your PCP. You may also visit a participating gynecologist for a routine GYN exam and Pap smear without a referral.
- Annual mammography screening for asymptomatic women age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their PCP.

Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.

- Routine immunizations (except those required for travel or work).
- Periodic eye examinations. You may visit a participating provider without a referral for one exam every 24 months.
- Prescription lenses and frames, including contact lenses, subject to any allowances shown in the “Summary of Benefits.”
- Routine hearing screenings performed by your PCP as part of a routine physical examination.

## Specialty and Outpatient Care

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

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see “In Case of Emergency”).

- Home health services provided by a participating home health care agency, including:
  - skilled nursing services provided or supervised by an RN.
  - services of a home health aide for skilled care.
  - medical social services provided or supervised by a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.
- Outpatient hospice services for a Plan participant who is terminally ill, including:
  - counseling and emotional support.
  - home visits by nurses and social workers.
  - pain management and symptom control.
  - instruction and supervision of a family member.

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

- bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
  - homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
  - respite care when the patient's family or usual caretaker cannot, or will not, attend to the patient's needs.
- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, removal of tumors and orthodontogenic cysts).
  - Reconstructive breast surgery following a mastectomy, including:
    - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
    - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
    - physical therapy to treat the complications of the mastectomy, including lymphedema.
  - Infertility services to diagnose and treat the underlying medical cause of infertility. You may obtain the following **basic** infertility services from a participating gynecologist or infertility specialist **without** a referral from your PCP:
    - initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
    - evaluation of ovulatory function,
    - ultrasound of ovaries at an appropriate participating radiology facility,
    - postcoital test,
    - hysterosalpingogram,
    - endometrial biopsy, and
    - hysteroscopy.

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

- Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Certain prosthetics require preauthorization by Aetna.
- Durable medical equipment (DME), prescribed by a **physician** for the treatment of an illness or injury.

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

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

The request for any type of DME must be made by your **physician** and coordinated through Aetna.

- Obesity Treatment. Covered expenses include charges made by a **physician**, licensed or certified dietician, nutritionist or **hospital** for the non-surgical treatment of obesity for the following outpatient weight management services:
  - An initial medical history and physical exam;
  - Diagnostic tests given or ordered during the first exam; and
  - Prescription drugs.

Covered expenses include one **morbid obesity** surgical procedure, within a two-year period, beginning with the date of the first **morbid obesity** surgical procedure, unless a multi-stage procedure is planned, but only when you have a:

- **Body mass index** (BMI) exceeding 40; or
- BMI greater than 35 in conjunction with any of the following co-morbidities any one of which is aggravated by the obesity:

Coronary heart disease;

Type 2 diabetes mellitus;

Clinically significant obstructive sleep apnea; or

Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management.

Unless specified above, not covered under this benefit are charges incurred for: Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in this booklet.

## **Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice**

If you are hospitalized by a participating PCP or specialist (with prior referral except in emergencies), you receive the benefits listed below. See “Behavioral Health” for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your PCP) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility. (Physician visits during the confinement are limited to 35 visits.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Intensive or special care facilities.
- Visits by your PCP while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
  - cardiac rehabilitation, and
  - pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic resonance imaging.
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-

related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

## Maternity

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

You do not need a referral from your PCP for visits to your participating obstetrician. A list of participating obstetricians can be found in your provider directory or on DocFind (see “Provider Information”).

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

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

## Behavioral Health

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

### Mental Health Treatment

The Plan covers the following services for mental health treatment:

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

### Treatment of Alcohol and Drug Abuse

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

- **Inpatient** care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your PCP.

Rehabilitation services are **not** covered.

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

- **Inpatient** care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- **Inpatient** medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an appropriately licensed facility.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your PCP.

- **Outpatient** visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.

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

### **Mental Disorders Benefits**

You are covered for treatment of a **mental disorder** through **participating behavioral health providers** as follows:

- **Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and are subject to the maximums, if any, shown on the Summary of Benefits.**
- Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, hospital or non-hospital residential treatment facility, appropriately licensed by the Department of Health or its equivalent. Coverage, if applicable, is subject to the maximums, if any, shown on the Summary of Benefits.

### **Substance Abuse Benefits**

You are covered for the following services as authorized and provided by **participating behavioral health providers**:

- Outpatient care benefits are covered for **detoxification**. Benefits include diagnosis, medical treatment and medical referral services (including **referral** services for appropriate ancillary services) by your **PCP** for the abuse of or addiction to alcohol or drugs. **Substance abuse rehabilitation** services are not covered.
- **Inpatient care benefits are covered for detoxification**. Benefits include medical treatment and **referral** services for **substance abuse** or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; **physicians**, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies. **Substance abuse rehabilitation** services are not covered.

You are covered for the following services as authorized and provided by **participating behavioral health providers**:

- Outpatient care benefits are covered for **detoxification**. Benefits include diagnosis, medical treatment and medical referral services (including **referral** services for appropriate ancillary services) by your **PCP** for the abuse of or addiction to alcohol or drugs.
- You are entitled to outpatient visits to a **participating behavioral health provider** upon **referral** by your **PCP** for diagnostic, medical or therapeutic substance abuse rehabilitation services. Coverage is subject to the limits, if any, shown on the Summary of Benefits.
- **Inpatient care benefits are covered for detoxification**. Benefits include medical treatment and **referral** services for **substance abuse** or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; **physicians**, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.
- You are entitled to medical, nursing, counseling or therapeutic **substance abuse rehabilitation** services in an inpatient, **hospital** or non-hospital **residential treatment facility**, appropriately licensed by the Department of Health, upon **referral** by your **participating behavioral health provider** for alcohol or drug abuse or dependency. Coverage is subject to the limits, if any, shown on the Summary of Benefits.

# Exclusions and Limitations

## Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by The Plan.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
  - reconstructive surgery to correct the results of an injury.
  - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
  - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
- Custodial care and rest cures.
- Dental care and treatment, except as specified under "Your Benefits". The Plan does not cover:
  - care, filling, removal or replacement of teeth,
  - dental services related to the gums,
  - apicoectomy (dental root resection),
  - orthodontics,
  - root canal treatment,
  - soft tissue impactions,
  - alveolectomy,
  - augmentation and vestibuloplasty treatment of periodontal disease,
  - prosthetic restoration of dental implants, and
  - dental implants.
- Drugs and medicines which by law need a physicians prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.
- Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.

This exclusion will not apply to drugs:

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

Refer to the "Glossary" for a definition of "experimental or investigational."
- False teeth.



- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids, eyeglasses, or contact lenses or the fitting thereof, except as specified under “Your Benefits.”
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work.
- Implantable drugs.
- Infertility services, except as described under “Your Benefits.” The Plan does not cover:
  - purchase of donor sperm and any charges for the storage of sperm.
  - purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
  - cryopreservation and storage of cryopreserved embryos.
  - all charges associated with a gestational carrier program (surrogate parenting) for the Plan participant or the gestational carrier.
  - drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
  - injectable infertility drugs.
  - the costs for home ovulation prediction kits.
  - services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.
  - services for females with FSH levels greater than 19 mIU/ml on day 3 of the menstrual cycle.
- Oral and implantable contraceptive drugs and devices, except when prescribed to treat certain medical conditions.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips.
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Private duty or special nursing care.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy’s amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
  - obtaining or continuing employment,
  - obtaining or maintaining any license issued by a municipality, state or federal government,
  - securing insurance coverage,
  - travel, and
  - school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.
- Services and supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.

- Specific injectable drugs, including:
  - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health, injectable drugs not considered medically necessary or used for cosmetic, performance, or enhancement purposes, or not specifically covered under this plan,
  - drugs related to treatments not covered by the Plan, and
  - drugs related to the treatment of infertility, contraception, and performance-enhancing steroids.
  - Specific non-standard allergy services and supplies, including (but not limited to):
  - skin titration (rinkel method),
  - cytotoxicity testing (Bryan's Test),
  - treatment of non-specific candida sensitivity, and
  - urine autoinjections.
- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):
  - primal therapy.
  - chelation therapy.
  - rolfing.
  - psychodrama.
  - megavitamin therapy.
  - purging.
  - bioenergetic therapy.
  - vision perception training.
  - carbon dioxide therapy.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to medical treatment of the retarded individual as described under "Your Benefits."
- Treatment of occupational injuries and occupational diseases, including injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does. If you are covered under a Workers' Compensation law or similar law, and submit proof that you are not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational," regardless of cause.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
  - treatment performed by placing a prosthesis directly on the teeth,
  - surgical and non-surgical medical and dental services, and
  - diagnostic or therapeutic services related to TMJ.
- Weight: Any treatment, drug, service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as provided by the booklet, including (but not limited to):
  - Liposuction, banding, gastric stapling, gastric bypass and other forms of bariatric surgery; surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
  - Counseling, coaching, training, hypnosis or other forms of therapy; and

-Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancements.

## **Limitations**

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

# In Case of Medical Emergency

## Guidelines

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

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

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

### Some examples of emergencies are:

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

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

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

## Follow-Up Care After Emergencies

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

## Urgent Care

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

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

## What to Do Outside Your Aetna Service Area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in

clinic, or an urgent care center. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings. You should call your PCP before receiving treatment from a non-participating urgent care provider.

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

# Special Programs

## Incentives

In order to encourage covered persons to access certain medical services when deemed appropriate by the covered person in consultation with his or her **physician** or other service provider, Aetna may, from time to time, offer to waive or reduce a member's copayment, coinsurance, and/or a deductible otherwise required under the plan or offer coupons or other financial incentives. Aetna has the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

## Wellness Incentive

Upon completion of a health assessment, you will be eligible to participate in wellness activities that align with your results. A list of wellness activities is available from Aetna or your Employer. To contact Aetna, call the Member Services phone number appearing on your ID card.

For completing one wellness activity, you will receive a Benefit Award Amount. Your plan may also have a maximum benefit per calendar year. The type and value of a Benefit Award Amount and the maximum benefit are chosen by your Employer. The Benefit Award Amount and the maximum benefit for completed wellness activities are shown in the Summary of Benefits. You may use your Benefit Award Amount to reduce any applicable deductible and/or payment limit required under this plan.

Only you and your dependent spouse are eligible for wellness incentives.

## Discount Arrangements

From time to time, Aetna may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, dentists, alternative medicine, wellness and healthy living providers to persons covered under the plan. Some of these arrangements may be made available through third parties who may make payments to Aetna in exchange for making these services available. The third party service providers are independent contractors and are solely responsible to covered persons for the provision of any such goods and/or services. Aetna reserves the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to covered persons nor does Aetna compensate providers for services they may render.

## Aetna Natural Products and Services<sup>SM</sup> Discount Program

You and your family can save on complementary health care products and professional services, not traditionally covered by your health benefit plan, through the Aetna Natural Products and Services discount program. All products and services are delivered through American Specialty Health Incorporated (ASH) and its subsidiaries, American Specialty Health Networks, Inc. (ASH Networks) and Healthyroads, Inc. ASH is a recognized leader in the complementary health care market.

You can access the following services from participating natural therapy professionals at reduced rates: acupuncture, chiropractic care, massage therapy and dietetic counseling. You can also purchase the following health-related products at a discount: over-the-counter vitamins, herbal and nutritional supplements, and natural products.

For more information or to locate participating natural therapy professionals, call the Member Services number on your ID card or visit the Aetna Natural Products and Services discount program page in Aetna Navigator by logging onto our secure member website at [www.aetna.com](http://www.aetna.com).

## Aetna Fitness<sup>SM</sup> Discount Program

You and your family members can save on gym memberships, programs and other products and services that support your healthy lifestyle with the Aetna Fitness discount program, offered with services provided by GlobalFit<sup>TM</sup>.

With the Aetna Fitness discount program, you have access to:

- Thousands of gyms nationwide and in Canada, including well-known national chains and independent local facilities
- Preferred rates\*
- Flexible membership options, guest privileges\*\* at participating network gyms when traveling and free guest passes\*\* to try participating gyms before joining
- Convenient billing options

Plus more support for your healthy lifestyles with access to:

- At-home weight loss programs
- Home exercise products and equipment
- One-on-one health coaching services\*\*\*

\*Participation in GlobalFit is for new gym members only. Membership to a gym of which you are now, or were recently, a member may not be available.

\*\*Not available at all gyms.

\*\*\*Provided by WellCall, Inc. through GlobalFit.

For more information, call the Member Services number on your ID card or visit the Aetna Fitness discount program page in Aetna Navigator by logging onto our website at [www.aetna.com](http://www.aetna.com). You can also contact GlobalFit directly at 1-800-298-7800.

## Aetna Vision Discount Program

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

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

## Hearing Discount Program

The Aetna Hearing<sup>SM</sup> discount program helps you and your family save on hearing exams, hearing aids and other hearing services. You can choose between two great offers at no additional premium cost:

- Hearing Care Solutions
- HearPO®

### Advantages of Hearing Care Solutions:

- Discounted rate of \$42 for hearing exams
- Hundreds of hearing aid models to choose from at fixed-rate pricing - savings represent up to 63 percent off standard retail
- 2-year supply of batteries (up to 96 cells) then a discount mail-order program
- In-office service at no charge one year after purchase
- Routine services (cleanings, instrument checks and battery door replacements) at no charge for the life of the instrument

### How Hearing Care Solutions works:

**To schedule an appointment, call Hearing Care Solutions directly at 1-866-344-7756. Hearing Care Solutions will schedule an appointment for you.**

You will also receive an informative welcome packet that includes information on hearing loss, what to expect at your first appointment and complete information on hearing instruments offered.

Hearing Care Solutions offers 2,000 providers in over 1,300 locations. To check the participating locations in your area, go to [www.aetna.com](http://www.aetna.com) and search DocFind®, our online provider directory. Or log in to Aetna Navigator®, your secure member website, and click on *Find a Doctor, Facility or Pharmacy* then "hearing".

### Advantages of HearPO:

- Discounted rate of \$48 for hearing exams (40 percent off the national retail cost)
- Savings on many styles from *complete-canal* to *behind-the-ear* hearing aids

- Cost break on the newest hearing aid technologies, including programmable and digital instruments from leading manufacturers
- Discounts on hearing aid repairs
- Free follow-up services for one year
- Free batteries (up to 160 cells per hearing aid)

**How HearPO works:**

HearPO includes access to over 1,600 participating locations. To find one near you, call HearPO customer service at **1-888-HEARING (1-888-432-7464)** or visit <http://hearpo.com/hearproviderlocations.asp>.

**To make an appointment, call HearPO to be sure you access the discounted rates for services and devices.**

- HearPO will then send you a validation packet.
- When you receive the validation packet, make an appointment with the selected provider.

Receive the discounts at the point of purchase. Also call HearPO to learn about their low price guarantee.

## **Aetna Weight Management<sup>SM</sup> Discount Program**

Aetna's Weight Management discount program can help you achieve your weight loss goals and develop a balanced approach to your active lifestyle. This program provides Aetna members and their eligible family members access to discounts on eDiets<sup>®</sup> diet plans and products, Jenny Craig<sup>®</sup> weight loss programs and products and Nutrisystem<sup>®</sup> weight loss meal plans.

### **eDiets**

You can save 30 percent on the online monthly plan membership dues. Once you enroll, you can upgrade to an online annual plan and save 20 percent on the already discounted annual plan price. When you enroll in an online plan, you can choose from over 20 online diet plans. Or, you can enroll in the Meal Delivery Plan (5-day or 7-day) and save 15 percent on the cost of food, delivered right to your door. Once you enroll in a plan, you'll receive one-on-one professional support, customized menus, unlimited access to the eDiets interactive community, a personalized fitness plan, live phone, chat and email support from certified and registered dietitians, 24/7 online member support and more.

You can also save 15 percent on all purchases from the eDiets Online Store and choose from DVDs, CDs, fitness and exercise equipment and more.

### **Jenny Craig**

Start with a FREE 30-day program\*, then receive 25 percent off a Jenny Craig Premium Program\* available at participating Jenny Craig centres and through Jenny Craig At Home. You also receive individual weekly schedule weight loss consultations, personalized menu planning, tailored activity planning, motivational materials, 24/7 customer care support, online support and free Jenny e-tools, message boards, live chat and much more.

### **Nutrisystem**

You can save 12 percent on any 28-day Nutrisystem<sup>®</sup> weight loss meal plan\*\* *plus* any other discount offers available from Nutrisystem at the time you enroll. Choose from Basic, Silver, Diabetic, Vegetarian and the Nutrisystem<sup>®</sup>Select<sup>™</sup> programs and take advantage of meal plans for men and women. Create your own 28-day menu (choose a breakfast, lunch, dinner and dessert for each day) or start with a pre-selected Favorite Foods Package, delivered right to your door. You'll also receive any easy-to-follow meal plan, free online membership with access to an extensive array of online tools, tracker, newsletter content and more, unlimited telephone and online counseling by trained weight loss counselors and dietitians, Online Mindset Makeover<sup>™</sup> behavioral guide and much more.

\*Food and, if applicable, shipping not included. Offer applies to initial membership fee only and is valid at participating centres in the U.S., Canada and Puerto Rico and through Jenny Craig At Home. Each offer is a separate offer and can be used only once per person. Restrictions apply.

\*\*Aetna discount offers do not apply to any program in which you are already enrolled. To receive the discounted rate, you must wait until your current program ends. Discounts do not apply to Nu-Kitchen Fresh for Nutrisystem and Nutrisystem Flex.



## Aetna Book<sup>SM</sup> Discount Program

The Aetna Book<sup>SM</sup> discount program provides you with access to discounts on books and other items purchased from the American Cancer Society Bookstore, the MayoClinic.com Bookstore and Pranamaya.

Through the American Cancer Society Bookstore and the MayoClinic.com Bookstore, you can choose from a variety of different books and other items like DVDs and greeting cards covering topics such as healthy living, staying in shape, living with certain health conditions and specific topics related to cancer. Through Pranamaya, choose from a variety of yoga DVDs, CDs, books and online videos featuring different yoga instructors and styles.

Through the American Cancer Society Bookstore, you will receive a 30% discount on your purchase of books, greeting cards and kits\* plus free standard shipping to U.S. addresses. You can choose from two main categories, offering a selection of over 50 different books for adults and children:

- Stay Well - healthy living, disease prevention, smoking cessation, etc.
- Get Well - cancer treatments, side effects, caregiving, etc.

You will receive a 10% discount when you order online at the MayoClinic.com Bookstore, plus receive free standard shipping. (*Mayo Clinic newsletters are regular price. No discounts apply.*)

You can choose from 25 different categories. There are over 30 different books and DVDs containing recipes for healthy living, advice on staying in shape, guidance for living with certain health conditions, and more. *Many publications are also available in Spanish\*\*!*

Through Pranamaya, you can save 25% on yoga DVDs, CDs, books and online videos.

Choose from a variety of products from well-renowned yoga instructors, including DVDs from Paul Grilley and Sarah Powers and Gary Kraftsow's acclaimed Viniyoga Therapy for Back Care series. You can also find products featuring different yoga styles, such as Vinyasa, Yin Yoga and more.

For more information, call the Member Services number on your ID card or visit the Aetna Book discount program page in Aetna Navigator by logging onto [www.aetna.com](http://www.aetna.com).

\*Includes two or more books combined as a special discount package.

\*\*Spanish publications are offered through Libros de Salud. No discounts apply. Libros de Salud is a third party Web site, which is not part of the MayoClinic.com Bookstore.

## Zagat Discounts

Zagat® offers a free 60-day Premium Membership to ZAGAT.com and a discount when you purchase a one-year, full-access ZAGAT.com Premium Membership. With your membership, you can access Zagat's trusted Ratings & Reviews for restaurants worldwide, receive discounts on purchases from the online Zagat Survey Shop and access Zagat Ratings & Reviews on the go with ZAGAT.com from your mobile device.

## At Home Products

Take advantage of money-savings discounts on health care products that you can use in the privacy and comfort of your home and that add up to savings for you and your family. So, get started, stay healthy and save money.

### Omron Deluxe Blood Pressure Monitor

Now you have the opportunity to track your own blood pressure at home with Omron Healthcare's Deluxe Blood Pressure Monitor.

You can purchase the monitor for \$59.99 (plus \$5.00 shipping and handling per unit) - a savings of \$40.00 off the current retail price of \$99.99.

### **Product Features - HEM-711 Deluxe Blood Pressure Monitor**

- Simple, silent, 1-touch automatic operation makes it easy to use.
- Extra-large digital display for systolic and diastolic blood pressure, pulse, data and time.
- ComFit Cuff with SigmaCuff technology - performed and expandable to easily fit regular and large arms, 9" to 17" circumference.
- IntelliSense technology for accurate, more comfortable readings.
- Advanced diagnostics, including hypertension indicator (according to American Health Association guidelines), irregular heartbeat detector and excessive body motion detector, 60 memory storage readings and data and time stamp, advanced averaging.
- 5-year limited warranty.

### **How it works**

- Please visit the Omron website at <http://omron.stage.suresource.com/aetna.asp>.
- Use the Aetna promotional code to take advantage of this exciting offer and receive your discount. The promo code is available through Aetna Navigator and Aetna Member Services.
- For more information or to place an order by phone call 1-866-896-5452 to speak to an Omron Customer Service representative.

*This product is subject to a warranty from the manufacturer. AETNA MAKES NO REPRESENTATIONS OR WARRANTIES AND DISCLAIMS ALL PRODUCT WARRANTIES, INCLUDING WITHOUT LIMITATION WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE AND NON-INFRINGEMENT. Aetna may receive a percentage of the total sales generated from the purchase of the Omron Healthcare Blood Pressure Monitor by Aetna customers.*

## **Member Health Education Programs**

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

To obtain information on Member Health Education Programs, call the toll-free number on your ID card or visit [http://www.aetna.com/products/health\\_education.html](http://www.aetna.com/products/health_education.html).

### **Adolescent Immunization**

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

### **Preventive Reminders**

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

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

## **Cancer Screening Programs**

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

## **Breast Cancer Screening**

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease. The mailer may also include information on participating mammography centers or information for women who have chosen a primary care physician with a capitated radiology office.

## **Cervical**

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

## **Colorectal**

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

## **Childhood Immunization Program**

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

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

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

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

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

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

## **Informed Health® Line**

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

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

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

## Numbers-to-Know™ -- Hypertension and Cholesterol Management

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

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

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

## Transplant Expenses

Once it has been determined that you or one of your dependents may require an organ transplant, you, or your **physician** should call the Aetna precertification department to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements found in the Certification for Admissions sections of this document. Organ means solid organ; stem cell; bone marrow; and tissue.

Benefits may vary if an **Institute of Excellence (IOE)** facility or non-**IOE** is used. In addition, some expenses listed below are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered as preferred care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a preferred facility for other types of services, will be covered at the non-preferred level. Please read each section carefully.

### *Covered Transplant Expenses*

Covered transplant expenses include the following:

Charges for activating the donor search process with national registries.

Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your: biological parent, sibling or child.

Inpatient and outpatient expenses directly related to a transplant.

Charges made by a **physician** or transplant team.

Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

Related supplies and services provided by the **IOE** facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

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

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

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

1. **Pre-transplant Evaluation/Screening:** Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.

2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant Event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell transplant
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one Transplant Occurrence:

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

### ***Limitations***

The transplant coverage does not include charges for:

Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.

Services and supplies furnished to a donor when recipient is not a covered person.

Home infusion therapy after the Transplant Occurrence.

Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.

Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.

Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

## **Women's Health Care**

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

### **Support for Women With Breast Cancer**

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

Breast cancer information

Second opinion options

Information about community resources

Benefit eligibility

Help with accessing participating providers for:

Wigs

Lymphedema pumps

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

### **Confidential Genetic Testing for Breast and Ovarian Cancers**

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

### **Direct Access for OB/GYN Visits**

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

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

## **Infertility Case Management and Education**

Aetna's Infertility Case Management program is a comprehensive education and information resource for women experiencing infertility.

Depending on the plan selected, the program may guide eligible members to a select network of infertility providers for services. If services are covered under the member's benefits plan, the Infertility Case Management unit will issue any necessary authorizations.

Aetna's Infertility Case Management unit is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility.

## **Beginning Right Maternity Program™**

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

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

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

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



# Eligibility

## Who Is Eligible to Join the Plan

You are eligible to enroll in the Plan if you are a full-time employee of your employer and you work or reside in the Plan's service area.

When you join the Plan, your spouse and your dependent children are also eligible to join. A dependent child must be under the age of 26. Coverage will continue until end of the year in which the child attains the limiting age.

You may enroll your natural child, foster child, stepchild, legally adopted child, a child under court order, or a grandchild in your court-ordered custody.

No person may be covered as both an employee and a dependent under the Plan, and no person may be covered as a dependent of more than one employee.

### If Your Child Is Adopted

Coverage for your legally adopted child is effective on the date the child is adopted or placed with you for adoption if you request coverage for the child in writing within 31 days of the placement.

### If Your Child Does Not Reside With You

If your child does not live with you, but they live in another Aetna service area, they can choose a PCP in that service area. Your child's coverage under the Plan will then be the same as yours.

A child covered by the Plan who does not reside in an Aetna service area can choose a PCP in your network and return to your network service area for care.

In the event of an emergency that occurs outside of your service area, out-of-area dependents should obtain necessary care as described under "In Case of Emergency," then contact their PCP to coordinate follow-up care.

### If Your Child Is Handicapped

Children of any age who are handicapped may also be covered. Your child is handicapped if:

- He or she is not able to earn his or her own living because of a mental or physical disability which started prior to the date he or she reached the limiting age; and
- He or she depends chiefly on you for support and maintenance.

You must provide proof of your child's handicap no later than 31 days after the child's coverage would otherwise end.

Coverage for a handicapped child ends on the first to occur of the following:

- The child's handicap ceases;
- You fail to provide proof that the handicap continues;
- The child fails to have a required examination by an Aetna participating PCP; or
- The child's coverage as a dependent under the Plan ceases for any reason **other than** attainment of the maximum age for dependent coverage.

### Qualified Medical Child Support Order (QMCSO)

A QMCSO is a court order requiring a parent to provide health care benefits to one or more children. Coverage under the Plan can be extended to a child who is covered by a QMCSO, if:

- The QMCSO is issued on or after the date your coverage becomes effective; and
- Your child meets the definition of an eligible dependent under the Plan; and
- You request coverage for the child in writing.

Coverage will be effective on the date of the court order.

## Enrollment

### New Employees

When you are first eligible to enroll in the Plan, you will be given enrollment and benefit information, including an enrollment form. You must complete the enrollment form and return it to your Human Resources representative within 31 days of the date you become eligible if you wish to participate in the Plan. If you do not return the form within the 31-day period, your employer will assume that you have waived coverage, and you will not be allowed to participate in the Plan until the next open enrollment period, unless you have a change in status.

### Open Enrollment

The annual open enrollment period is your opportunity to review your benefit needs for the upcoming year and to change your benefit elections, if necessary. Open enrollment is held each fall, and the elections you make will be in effect January 1 through December 31 of the following calendar year.

## Change in Status

You may change coverage any time during the year because of a change in your status. A change in status is:

- Your marriage, divorce, legal separation or annulment;
- The birth or adoption of a child;
- The death of your spouse or child;
- A change in the number of your dependents;
- A change in employment status for you, your spouse or your dependent; or
- The beginning or end of an unpaid leave of absence taken by you or your spouse.

Whenever you have a change in status, you must report the change by completing a change form, available from your Human Resources representative. The completed change form must be given to your Human Resources representative within 31 days of the event. Otherwise, you must wait until the next employer's open enrollment period.

**Note:** Newborn children are automatically covered for 31 days after birth. To continue the coverage beyond 31 days, you must apply by submitting a change form to your Human Resources representative within the 31-day period.

## Special Enrollment Period

You and your eligible dependents may be enrolled during special enrollment periods. A special enrollment period may apply when you or your eligible dependent loses other health coverage or when you acquire a new eligible dependent through marriage, birth, adoption, or placement for adoption.

### Special Enrollment Period for Certain Individuals Who Lose Other Health Coverage:

You or an eligible dependent may be enrolled during a special enrollment period, if requirements a, b, c, and d are met:

- a. you or your eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under the Plan.
- b. you or your eligible dependent previously declined coverage under the Plan;
- c. you or your eligible dependent loses coverage under the other group health plan or other health insurance coverage for one of the following reasons:
  - i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted; or
  - ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated because you or your dependent lose eligibility for the coverage or employer contributions towards the other coverage have been terminated.

Loss of eligibility includes the following:

- a loss of coverage as a result of legal separation, divorce, or death;
- termination of employment;
- reduction in the number of hours of employment;
- any loss of eligibility after a period that is measured by reference to any of the foregoing;
- termination of Plan coverage due to you or your dependent moving outside of the Plan's service area; and also the termination of health coverage including Non-HMO, due to plan termination;
- plan ceases to offer coverage to a group of similarly situated individuals;
- cessation of a dependent's status as an eligible dependent;
- termination of benefit package;
- with respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; and

d. you or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

Loss of eligibility does not include a loss due to failure of you or your dependent to pay **premiums** on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of this Plan Description.

You will need to enroll yourself or a dependent for coverage within:

- 31 days of the loss of coverage under the other group health plan or other health insurance coverage;
- 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

The **Effective Date of Coverage** will be the first day of the first calendar month following the date the completed request for enrollment is received.

You or your eligible dependent enrolling during a special enrollment period will not be subject to late enrollment provisions, if any described in this Summary Plan Description.

**Special Enrollment Period When a New Eligible Dependent is Acquired:**

When you acquire a new eligible dependent through marriage, birth, adoption or placement for adoption, the new eligible dependent ( as well as you and other eligible dependents, if not otherwise enrolled) may be enrolled during a special enrollment period.

The special enrollment period is a period of 30 days, beginning on the date of the marriage, birth, adoption or placement for adoption (as the case may be). If a completed request for enrollment is made during that period, the **Effective Date of Coverage** will be:

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement of adoption.

You or your eligible dependents enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this Summary Plan Description.

# When Coverage Ends

## Termination of Employee Coverage

Your coverage will end if:

- You voluntarily terminate coverage;
- Your employment terminates;
- You are no longer eligible for coverage;
- You do not make the required contributions;
- You become covered under another health care plan offered by your employer; or
- The Plan is discontinued.

## Termination of Dependent Coverage

Coverage for your dependents will end if:

- Your coverage ends for any of the reasons listed above;
- You die;
- Your dependent is no longer eligible for coverage;
- Your payment for dependent coverage is not made when due; or
- Dependent coverage is no longer available under the Plan.

## Continuing Coverage for Dependent Students on Medical Leave of Absence

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious **illness** or injury, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. Aetna may require a written certification from the treating **physician** which states that the child is suffering from a serious **illness** or injury and that the resulting leave of absence (or change in full-time student status) is medically necessary.

### **Important Note**

If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage. Please see the section, "If Your Child is Handicapped", for more information.

## Termination for Cause

A Plan participant's coverage may be terminated for cause. "For cause" is defined as:

- **Untenable relationship:** After reasonable efforts, Aetna and/or the Plan's participating providers are unable to establish and maintain a satisfactory provider-patient relationship with you or a Plan participant of your family. You will be given 31 days advance written notice of the termination of coverage.
- **Failure to make copayments:** You or a member of your family fails to make any required copayment or any other payment that you are obligated to pay. You will be given 31 days advance written notice of the termination of coverage.
- **Refusal to provide COB information:** You or a member of your family refuses to cooperate and provide any facts necessary for Aetna to administer the Plan's COB provision. You will be given 31 days advance written notice of the termination of coverage.
- **Furnishing incorrect or incomplete information:** You or a member of your family willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in, or obtaining benefits from, the Plan. Termination will be effective immediately.
- **Fraud against the Plan:** This may include, but is not limited to, allowing a person who is not a participant of the Plan to use your Aetna ID card. Termination will be effective immediately.
- **Misconduct:** You or a covered member of your family abuses the system, including (but not limited to) theft, damage to the property of a participating provider, or forgery of drug prescriptions. Termination will be effective immediately.

No benefits will be provided to you and your family members once coverage is terminated.

Any termination for cause is subject to review in accordance with the Plan's grievance process. You may request that Aetna conduct a grievance hearing within 15 working days after receiving notice that coverage has been or will be terminated. Coverage will be continued until a final decision on the grievance is rendered, provided you continue to make required contributions. Termination may be retroactive to the original date of termination if the final decision is in favor of Aetna.

## Family and Medical Leave

If your employer grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by your employer to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, your employer may recover from you the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is terminated because of your gross misconduct, you will not be eligible for COBRA continued coverage.

## **COBRA Continuation of Coverage**

You and your dependents have the right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue medical coverage under certain circumstances (called “qualifying events”) when you would otherwise lose coverage. To do so, you must pay up to 102% of the full regular cost of coverage.

### **Continuation of Coverage Following Termination of Employment or Loss of Eligibility**

You and your covered family members are eligible to continue coverage for up to 18 months if:

- You leave your employer for any reason other than gross misconduct; or
- You are no longer eligible because your working hours are reduced.

You may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue their own coverage.

If you or your dependent is disabled, as defined by the Social Security Administration, at the time of the qualifying event or becomes disabled within 60 days of the event, you may be entitled to an extra 11 months of coverage, for a total of 29 months. You must notify your Human Resources representative of the disability before the end of the original 18-month period to receive the extension, and you must pay up to 150% of the full cost of coverage for every month after the 18<sup>th</sup> month. Coverage may be continued for the disabled individual and for any family member for whom coverage is already being continued under COBRA, as well as for your newborn or newly adopted child who was added after the date COBRA continuation began. COBRA continuation of benefits will end on the first day of the month that begins more than 30 days after the final determination under Title II or XVI of the Social Security Act that the disabled individual is no longer disabled.

### **Continuation of Coverage Due to Other Qualifying Events**

Your eligible dependents can continue coverage for up to 36 months if coverage would otherwise cease because:

- You die;
- You are divorced;
- You stop making contributions for a spouse from whom you are legally separated;
- You become entitled to Medicare; or
- A covered child is no longer eligible under the Plan.

If one of the above events occurs while you or a covered dependent have already continued coverage due to the termination of your employment or your loss of eligibility, your dependent may extend coverage beyond the original 18-month continuation period, but for no more than a total of 36 months from the date coverage would originally have ended.

## **Applying for COBRA Continuation**

Your Human Resources representative will give you information about how to continue COBRA coverage at the time you become eligible.

You must inform your employer of any status changes that would make your dependents eligible for COBRA coverage within 60 days of the later to occur of:

- The occurrence of the event; and
- The date coverage would terminate due to the event.

To ensure that there is no break in coverage, the election to continue coverage must be made within 60 days of:

- The date coverage would terminate due to the event; or
- The date your employer informs your dependents of their right to continue coverage;

whichever happens later.

If you do not make your election within 60 days, you will lose your COBRA continuation rights.

## **When COBRA Continuation Coverage Ends**

Continuation coverage will end on the earliest date that:

- The COBRA continuation period expires.
- You or your family members do not make the required contributions.
- You or your family members become covered under another group health plan, unless that plan contains a provision that restricts the payment of benefits for a pre-existing condition. Once the pre-existing condition clause of the new plan ceases to apply, your COBRA coverage will cease.
- You or your family members become enrolled in Medicare. (Coverage could continue for those individuals not eligible for Medicare for up to 36 months from the original qualifying event, provided those family members otherwise remain eligible.)
- Your employer terminates this health plan.

## **Portability of Coverage**

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your employer will give you a certificate confirming your participation in the Plan when your employment terminates. Certificates can be obtained from your Human Resources representative.

## Conversion From Group to Individual Membership

Most Plan participants who terminate employment or cease to be eligible for benefits may convert to individual membership without evidence of good health if their place of residence remains within the Aetna service area. If you have been continuously enrolled in the Plan for three months, you and/or your eligible dependent may apply to Aetna for a conversion policy within 31 days after:

- Termination of employment.
- Loss of group membership.
- Loss of dependent status.
- Termination of any continuation coverage required under federal or state law.

The converted coverage will not provide the same benefits as your employer HMO Plan. The rate you pay will be the premium charged for individual policies.

For necessary forms and information about the conversion plan, call the toll-free number on your ID card.

**Note:** Certain benefits cannot be converted.



# Claims

## Coordination of Benefits

If you have coverage under other group plans, the benefits from the other plans will be taken into account if you have a claim. This may mean a reduction in benefits under the Plan.

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

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

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

- The plan without a coordination of benefits (COB) provision determines its benefits before the plan that has such a provision.
- The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent. If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows:
  - The plan that covers the person as a dependent of a working spouse will pay first;
  - Medicare will pay second; and
  - The plan that covers the person as a retired employee will pay third.
- Except for children of divorced or separated parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first. When both parents' birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan doesn't have the parent birthday rule, the other plan's COB rule applies.
- When the parents of a dependent child are divorced or separated:
  - If there is a court decree which states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the parent birthday rule, immediately above, applies.
  - If a court decree gives financial responsibility for the child's medical, dental or other health care expenses to one of the parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent.
  - If there is no such court decree, the order of benefits will be determined as follows:
    - the plan of the natural parent with whom the child resides,
    - the plan of the stepparent with whom the child resides,
    - the plan of the natural parent with whom the child does not reside, or
    - the plan of the stepparent with whom the child does not reside.
- If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.
- The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.
- If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

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

- The amount normally reimbursed for covered benefits under this Plan,  
*Less*
- Benefits payable from your other plan(s).

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

## **Subrogation and Right of Recovery Provision**

As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injuries, illness or condition, including the liability insurer of such party, or any insurance carrier providing medical expense or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage. For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injuries, illness, to the full extent of benefits provided or to be provided by the Plan.

In addition, if a Covered Person receives any payment from any Responsible Party as a result of an injury or illness, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury or illness, up to and including the full amount the Covered Person receives from all Responsible Parties. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury or illness, he or she will serve as a constructive trustee over the fund that constitutes such payment. Failure to hold such fund in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Further, the Plan will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment, or otherwise, that a Covered Person receives from Responsible Party as a result of the Covered Person's illness, injuries, or condition.

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

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

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

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

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

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

## Claim Procedures

A claim occurs whenever a Plan participant requests:

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

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

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

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

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

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown below. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see “Complaints and Appeals” for more information about appeals.

<b>Type of Claim</b>	<b>Response Time</b>
<p><b>Urgent care claim:</b> a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> <li>• Seriously jeopardize your life or health, or your ability to regain maximum function; or</li> <li>• Subject you to severe pain that cannot be adequately managed without the requested care or treatment.</li> </ul>	As soon as possible but not later than 72 hours.
<p><b>Pre-service claim:</b> a claim for a benefit that requires Aetna’s approval of the benefit in advance of obtaining medical care.</p>	15 calendar days
<p><b>Concurrent care claim extension:</b> a request to extend a previously approved course of treatment.</p>	<p>Urgent care claim - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment</p> <p>Other claims - 15 calendar days</p>
<p><b>Concurrent care claim reduction or termination:</b> a decision to reduce or terminate a course of treatment that was previously approved.</p>	With enough advance notice to allow the Plan participant to appeal
<p><b>Post-service claim:</b> a claim for a benefit that is not a pre-service claim.</p>	30 calendar days

### Extensions of Time Frames

The time periods described in the chart may be extended.

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

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

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

## **Grievances and Appeals**

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

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

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

### **Grievances**

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

### **Appeals of Adverse Benefit Determinations**

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

The Plan provides for two levels of appeal plus an option to seek External Review of the adverse benefit determination. If you are dissatisfied with the outcome of your level one appeal and wish to file a level two appeal, your appeal must be filed no later than 60 days following receipt of the level one notice of adverse benefit determination. The following chart summarizes some information about how appeals are handled for different types of claims.

Type of Claim	Level One Appeal	Level Two Appeal
<p>Urgent care claim: a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> <li>• Seriously jeopardize your life or health, or your ability to regain maximum function; or</li> <li>• Subject you to severe pain that cannot be adequately managed without the requested care or treatment.</li> </ul>	<p>36 hours</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>	<p>36 hours</p> <p>Review provided by Appeals Committee.</p>
<p><b>Pre-service claim:</b> a claim for a benefit that requires Aetna’s approval of the benefit in advance of obtaining medical care.</p>	<p>15 calendar days</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>	<p>15 calendar days</p> <p>Review provided by Appeals Committee.</p>
<p><b>Concurrent care claim extension:</b> a request to extend a previously approved course of treatment.</p>	<p>Treated like an urgent care claim or a pre-service claim depending on the circumstances.</p>	<p>Treated like an urgent care claim or a pre-service claim depending on the circumstances.</p>
<p><b>Post-service claim:</b> a claim for a benefit that is not a pre-service claim.</p>	<p>30 calendar days</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>	<p>30 calendar days</p> <p>Review provided by Appeals Committee.</p>

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

Depending on the type of appeal, you and/or an authorized representative may attend the Level 2 appeal hearing and question the representative of Aetna and any other witnesses, and present your case. The hearing will be informal. You may bring your physician or other experts to testify. Aetna also has the right to present witnesses.

If the Level One and Level Two appeals uphold the original adverse benefit determination, you may have the right to pursue an external review of your claim. See “External Review” for more information.

## External Review

You may file a voluntary appeal for external review of any final appeal determination that qualifies.

You must complete the two levels of appeal described above before you can appeal for external review. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal. You must request this voluntary level of review within 60 days after you receive the final denial notice.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

An external review is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials and denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment. You may request a review by an external review organization (ERO) if:

- You have received notice of the denial of a claim; and
- Your claim was denied because the care was not medically necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds \$ 500; and
- You have exhausted the applicable Plan appeal process.

The final claim denial letter you receive will describe the process to follow if you wish to pursue an external review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. The form must be accompanied by a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the Request for External Review Form, and will follow the applicable plan's contractual documents and plan criteria governing the benefits. You will generally be notified of the decision of the External Review Organization within 30 days of Aetna's receipt of your request form and all necessary information. An expedited review is available if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within 3-5 calendar days after Aetna receives the request.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization.

## Claim Fiduciary

For the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), Aetna is a fiduciary with complete authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its fiduciary responsibility, Aetna has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

Aetna has the right to adopt reasonable policies, procedures, rules, and interpretations of the Plan to promote orderly and efficient administration. Aetna may not act arbitrarily and capriciously, which would be an abuse of its discretionary authority.

Your employer is responsible for making reports and disclosures required by ERISA, including the creation, distribution, and final content of:

- Summary plan descriptions;
- Summary of material modifications; and
- Summary annual reports.



# Member Services

## Member Services Department

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

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

- Ask questions about benefits and coverage;
- Notify Aetna of changes in your name or telephone number;
- Change your PCP; or
- Notify Aetna about an emergency.

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

## Internet Access

You can access Aetna on the internet at [http://www.aetna.com/members/member\\_services.html](http://www.aetna.com/members/member_services.html) to conduct business with the Member Services department electronically.

When you visit the Member Services site, you can:

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

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

## InteliHealth<sup>®</sup>

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

## Clinical Policy Bulletins

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

## Aetna Navigator™

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

With Aetna Navigator, you can:

- Print instant eligibility information
- Request a replacement ID card
- Select a physician who participates in the Aetna network
- Check the status of a claim
- Link to a voluntary Health Risk Assessment tool
- Use the hospital comparison tool to compare hospital outcome information for medical care provided by hospitals in your area
- Estimate the cost of common health care services
- Receive personalized health and benefits messages
- Contact Aetna Member Services

# Rights and Responsibilities

## Your Rights and Responsibilities

### As a Plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan.
- Obtain primary and preventive care from the PCP you chose from the Plan's network.
- Change your PCP to another available PCP who participates in the Aetna network.
- Obtain covered care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your PCP or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit their website at [www.aetna.com](http://www.aetna.com). Select DocFind from the drop-down menu under Quick Tools, then under "How do I learn more about:" select the type of plan you're enrolled in.
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered, and any applicable limitations or exclusions.
- Get information about copayments and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

### As a Plan participant, you have the responsibility to:

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

## **Patient Self-Determination Act (Advance Directives)**

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

### **What Is an Advance Directive?**

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

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

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

### **What Is a Living Will?**

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

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

### **What Is a Durable Power of Attorney for Health Care?**

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

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

### **Who Decides About My Treatment?**

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

## **How Do I Know What I Want?**

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

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

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

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

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

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

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

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

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

## **Do I Have to Execute an Advance Directive?**

No. It is entirely up to you.

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

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

## **Can I Change My Mind After Writing an Advance Directive?**

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

## **What Is the Plan's Policy Regarding Advance Directives?**

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

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

## **How Can I Get More Information About Advance Directives?**

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

## Federal Notices

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

### The Newborns' and Mothers' Health Protection Act

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

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

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

### The Women's Health and Cancer Rights Act

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

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

This coverage will be provided in consultation with the attending physician and the patient.

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

# Plan Information

## Your ERISA Rights

The Employee Retirement Income Security Act of 1974, known as ERISA, guarantees your rights as a Plan participant. ERISA provides that all Plan participants shall be entitled to:

### Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

### Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse and/or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months after your enrollment date in your coverage under this Plan.

### Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Assistance With Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance with obtaining documents from the Plan Administrator, you should contact:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue, N.W.  
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



## General Information About the Plan

Employer/Plan Sponsor	Middlesex County Joint Health Insurance Fund One Commerce Street, 2005 Market Philadelphia, PA 19103
Employer Identification Number	22-3382140
Plan Number	501
Plan Type	Welfare: Medical
Plan Year	The Plan Year runs from January 1 to December 31.
Plan Administrator	Middlesex County Joint Health Insurance Fund One Commerce Street, 2005 Market Philadelphia, PA 19103
Type of Administration	The Plan is administered under a contract with Aetna Life Insurance Company.
Source of Contributions to the Plan	Employer and employee
Agent for Service of Legal Process	the Plan Administrator

### Amendment or Termination of the Plan

Your employer has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified.

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

### Plan Documents

This plan description covers the major features of the HMO Plan administered by Aetna Life Insurance Company, effective January 1, 2011. The plan description has been designed to provide a clear and understandable summary of the Plan, and serves as the Summary Plan Description (SPD) required for plans subject to ERISA.

# Glossary

**Advanced Reproductive Technology ("ART")** - means:

- a. in vitro fertilization (IVF);
- b. gamete intra-fallopian transfer (GIFT);
- c. zygote intra-fallopian transfer (ZIFT);
- d. cryopreserved embryo transfers; or
- e. intra-cytoplasmic sperm injection (ICSI) or ovum microsurgery.

**Annual out-of-pocket maximum** - means the maximum amount a Plan participant must pay toward covered expenses in a calendar year. Once you reach your annual out-of-pocket maximum, the Plan pays 100% of covered expenses for the remainder of the calendar year. Copays apply toward the annual out-of-pocket maximum.

Certain expenses do *not* apply toward the annual out-of-pocket maximum:

- Charges for services that are not covered by the Plan.
- Copayments for prescription drugs.

**Behavioral Health Provider** - means a licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

**Body Mass Index** - means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

**Brand Name Drug** - means a prescription drug that is protected by trademark registration.

**Copayment** (copay) - means the fee that must be paid by a Plan participant to a participating provider at the time of service for certain covered expenses and benefits, as described in the "Summary of Benefits."

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

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

**Covered services and supplies** (covered expenses) - means the types of medically necessary services and supplies described in "Your Benefits."

**Creditable Coverage**. - Coverage of the Plan participant under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, including coverage received under a plan established or maintained by a foreign country or political subdivision as well as one established and maintained by the government of the United States, any health benefit plan under section 5(e) of the Peace Corps Act and the State Children's Health Insurance Program (S-Chip). Creditable Coverage does not include coverage only for accident; Workers' Compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.

**Custodial care** - means any service or supply, including room and board, which:

- Is furnished mainly to help you meet your routine daily needs; or
- Can be furnished by someone who has no professional health care training or skills; or
- Is at a level such that you have reached the maximum level of physical or mental function and are not likely to make further significant progress.

**Detoxification** - means the process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other

means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.

**Durable medical equipment (DME)** - means equipment determined to be:

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

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

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

With respect to emergency services furnished in a hospital emergency department, the Plan does not require prior authorization for such services if you arrive at the emergency medical department with symptoms that reasonably suggest an emergency condition, based on the judgment of a prudent layperson, regardless of whether the hospital is a participating provider. All medically necessary procedures performed during the evaluation (triage and treatment of an emergency medical condition) are covered by the Plan.

**Experimental or investigational** - means services or supplies that are determined by Aetna to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:

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

**Generic Drug** - means a prescription drug which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

**Home health services** - means those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by Aetna.

**Hospice care** - means a program of care that is:

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

**Hospital** - means an institution rendering inpatient and outpatient services, accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation or specialty institution.

**Infertility** - means:

- For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.
- For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

**Infertility Case Management** - means a program that consists of:

- a. evaluation of infertile member's medical records to determine whether ART Services are Medically Necessary and are reasonably likely to result in success;
- b. determination of whether ART Services are Covered Services and Supplies for the member;
- c. pre-authorization for ART Services by a Participating ART Specialist when ART Services are Medically Necessary, reasonably likely to result in success, and are Covered Services and Supplies; and
- d. case management for the provision of ART Services for eligible members.

**Institute of Excellence (IOE)**- This is a facility that is contracted with Aetna to furnish particular services and supplies to you and your covered dependents in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

**Medical services** - means those professional services of physicians or other health professionals, including medical, surgical, diagnostic, therapeutic and preventive services authorized by Aetna.

**Medically necessary** - means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the "Your Benefits" section of this booklet. To be medically necessary, the service or supply must:

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

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

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

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

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;

- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting; or
- Experimental services and supplies, as determined by Aetna.

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

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

**Mental Disorders** - means an illness commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker.

The following conditions are considered a **mental disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive-compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (including Autism).
- Psychotic Disorders/Delusional Disorder.
- Schizo-affective Disorder.
- Schizophrenia.

**Morbid Obesity** - means a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

**Outpatient** - means:

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

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

**Participating ART Specialist** - means a Specialist who has entered into a contractual agreement with Aetna for the provision of ART Services.

**Participating provider** - means a provider that has entered into a contractual agreement with Aetna to provide services to Plan participants.

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

**Plan benefits** - means the medical services, hospital services, and other services and care to which a Plan participant is entitled, as described in this booklet.

**Plan participant** - means an employee or covered dependent.

**Preferred Drug Guide** - means a listing of prescription drugs and insulin established by the health plan, that includes both brand name prescription drugs and generic prescription drugs. This list is subject to periodic review and modification by Aetna. Drugs listed on the **preferred drug guide** are covered under the prescription drug plan, which copayments as shown in the "Summary of Benefits".

**Preferred Drug Guide Exclusions List** - means a list of prescription drugs in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by Aetna.

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

**Provider** - means a physician, health professional, hospital, skilled nursing facility, home health agency, or other recognized entity or person licensed to provide hospital or medical services to Plan participants.

**Psychiatric Physician** - means a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, **substance abuse** or **mental disorders**.

**Referral** - means specific written or electronic direction or instruction from a Plan participant's PCP, in conformance with Aetna's policies and procedures, which directs the Plan participant to a participating provider for medically necessary care.

**Residential Treatment Facility (Mental Disorders)** - means an institution that meets all of the following requirements:

- On-site licensed **behavioral health provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

**Residential Treatment Facility (Alcoholism and Substance Abuse)** - means an institution that meets all of the following requirements:

- On-site licensed **behavioral health provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.

- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.
- On-site, licensed **behavioral health provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

**Residential Treatment Facility (Substance Abuse)** - means an institution that meets all of the following requirements:

- On-site licensed **behavioral health provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7 days a week, which must be actively supervised by an attending **physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.
- On-site, licensed **behavioral health provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

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

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

**Specialist** - means a physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

**Substance abuse** - means any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

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

**Urgent medical condition** - means a medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP.



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