

 Anchorage School District

**Open Choice Medical Plan**

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# Your Group Coverage Plan

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Coverage in this Plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (called Aetna) only to the extent benefits are not the liability of your Employer. The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the group contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the group contract.



President

Aetna Life Insurance Company  
(A Stock Company)

Group Policy: GP-658742  
Cert. Base: 1  
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"This is an electronic version of the Booklet on file with your Employer and Aetna Life Insurance Company, Hartford, CT. In case of a discrepancy between this electronic version and the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth by such group insurance contract will prevail. To obtain a printed copy of this Booklet, please contact your Employer."

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# Health Expense Coverage

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Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that Aetna will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury or disease which occurred, commenced or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

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## Prescription Drug Expense Coverage

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all **prescription drugs**. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet-Certificate.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

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### Covered Prescription Drug Expenses

This Plan pays the benefits shown below for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by a **pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **pharmacy's** charge for the drug is more than the **copay** per **prescription** or refill.

A benefit will be paid at the preferred level of coverage for a **prescription drug** dispensed by a **non-preferred pharmacy** for an **emergency condition**.

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

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## Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by a **preferred pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the **preferred pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf.

The Benefit Amount for each covered **prescription drug** or refill dispensed by a **non-preferred pharmacy** will be an amount equal to the Payment Percentage of the **non-preferred pharmacy's** charge for the drug except for an **emergency condition**, in which case the benefit will be payable at the preferred level of coverage.

## Limitations

No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 30 day supply of any drug dispensed by a **mail order pharmacy**.
- For more than a 30 day supply per **prescription** or refill. However, this limitation does not apply to a supply of up to 90 days per **prescription** or refill for drugs which are provided by a **mail order pharmacy**.
- For the administration or injection of any drug.
- For the following injectable drugs:

fertility drugs;

allergy sera or extracts; and

Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year.

- For any refill of a drug that is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:

if the **prescriber** has not specified the number of refills; or

if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.

- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by your Employer.
- For any drugs which do not, by federal or state law, require a prescription order (i.e. an over-the-counter (OTC) drug), even if a prescription is written.
- Any **Prescription Drug** for which there is an over-the-counter (OTC) product which has the same active ingredient and strength.
- For immunization agents.
- For biological sera and blood products.
- For nutritional supplements.
- For any fertility drugs.
- For any smoking cessation aids or drugs.

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- For appetite suppressants.
  - For a **prescription drug** dispensed by a **mail order pharmacy** that is not a **preferred pharmacy**.
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## Comprehensive Medical Expense Coverage

Comprehensive Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet-Certificate.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Medical Expenses described below.

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### Covered Medical Expenses

They are the expenses for certain **hospital** and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

#### **Hospital Expenses**

##### *Inpatient Hospital Expenses*

**Charges** made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.

##### *Outpatient Hospital Expenses*

Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

#### **Convalescent Facility Expenses**

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physician's** services.
- Medical supplies.

Benefits will be paid for no longer than the Convalescent Days during any one calendar year.

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### *Limitations To Convalescent Facility Expenses*

This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

### **Home Health Care Expenses**

Home health care expenses are covered if:

- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or **convalescent facility**:

medical supplies;

drugs and medicines prescribed by a **physician**; and

lab services provided by or for a **home health care agency**.

There is a maximum to the number of visits covered in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

### *Limitations To Home Health Care Expenses*

This section does not cover charges made for:

- Services or supplies that are not a part of the **home health care plan**.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation.

### **Second Surgical Opinion Expenses**

Charges of a **physician** for a second surgical opinion on the need or advisability of performing a surgical or oral surgical procedure:

- for which the charges are a Covered Medical Expense; and
- which is recommended by the first **physician** who proposed to perform the surgery; and
- which is not for an **emergency condition**.

A benefit is also paid for charges made for a third surgical opinion. This will be done when the second one does not confirm the recommendation of the first **physician** who proposed to perform the surgery.

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A surgical opinion is:

- an exam of the person; and
- x-ray and lab work; and
- a written report by the **physician** who renders the opinion.

The surgical opinion must both:

- be performed by a **physician** who is certified by the American Board of Surgery or other specialty board; and
- take place before the date the proposed surgery is scheduled to be done.

Benefits are not paid for a surgical opinion if the **physician** who renders the surgical opinion is associated or in practice with the first **physician** who recommended and proposed to perform the surgery.

## **Hospice Care Expenses**

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

### *Facility Expenses*

The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**;
- **convalescent facility**;

which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:
  - pain control; and
  - other acute and chronic symptom management.
- Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Services and supplies furnished to a person while not confined as a full-time inpatient.

### *Other Expenses*

Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:
  - assessment of the person's:
    - social, emotional, and medical needs; and
    - the home and family situation;
    - identification of the community resources which are available to the person; and
    - assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.

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- Consultation or case management services by a **physician**.
  - Physical and occupational therapy.
  - Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
  - Medical supplies.
  - Drugs and medicines prescribed by a **physician**.

Charges made by the providers below, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:
  - physical and occupational therapy;
  - part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;
  - medical supplies;
  - drugs and medicines prescribed by a **physician**; and
  - psychological and dietary counseling.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

### **Contraception Expenses**

Covered Medical Expenses include:

- charges incurred for contraceptive drugs and contraceptive devices that by law need a physician's prescription; and that have been approved by the FDA.
- related outpatient contraceptive services such as:
  - consultations;
  - exams;
  - procedures; and
  - other medical services and supplies.

Not covered are:

- charges for services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer; and
- charges incurred for contraceptive services while confined as an inpatient.

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## Routine Physical Exams

The charges made by a **physician** for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. If charges made by a **physician** in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included as a part of the exam are:

- X-rays, lab, and other tests given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For your dependent child:

- The physical exam must include at least:
  - a review and written record of the patient's complete medical history;
  - a check of all body systems; and
  - a review and discussion of the exam results with the patient or with the parent or guardian.
- For all exams given to your dependent child under age 2, Covered Medical Expenses will not include charges for:
  - more than 6 exams performed during the first year of the child's life;
  - more than 2 exams performed during the second year of the child's life.
- For all exams given to your dependent child age 2 up to age 18, Covered Medical Expenses will not include charges for more than one exam in 12 months in a row.
- For all exams given to your dependent child age 18 and over, Covered Medical Expenses will not include charges for more than one exam in 12 months in a row.

For all exams given to you and your spouse, Covered Medical Expenses will not include charges for more than:

- one exam in 24 months in a row, if the person is under age 65; and
- one exam in 12 months in a row, if the person is age 65 or over.

Also included as Covered Medical Expenses are charges made by a **physician** for one annual routine gynecological exam.

Not covered are charges for:

- Services which are covered to any extent under any other group plan of your Employer.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a **hospital** or other facility for medical care.
- Services which are not given by a **physician** or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Vision, hearing, or dental exams.
- A **physician's** office visit in connection with immunizations or testing for tuberculosis.

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## Other Medical Expenses

- Charges made by a **physician**.
- Charges made by a **R.N.** or **L.P.N.** or a nursing agency for skilled nursing care.

As used here, "skilled nursing care" means these services:

Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.

Private duty nursing by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Not included as "skilled nursing care" is:

that part or all of any nursing care that does not require the education, training, and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs, and companionship activities; or

any private duty nursing care given while the person is an inpatient in a **hospital** or other health care facility; or

care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or

care provided solely for skilled observation except as follows:

for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:

change in patient medication;

need for treatment of an **emergency condition** by a **physician** or the onset of symptoms indicating the likely need for such treatment;

surgery; or

release from inpatient confinement; or

any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

- Charges for the following:

Drugs and medicines which by law need a **physician's** prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.

Diagnostic lab work and X-rays.

X-ray, radium, and radioactive isotope therapy.

Anesthetics and oxygen.

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Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

Repair of purchased equipment.

Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.

Artificial limbs and eyes. Not included are charges for:

eyeglasses;

vision aids;

hearing aids;

communication aids; and

orthopedic shoes, foot orthotics, or other devices to support the feet, unless **necessary** to prevent complications of diabetes.

### **National Medical Excellence Program ® (NME)**

If a person is an **NME Patient**, this Plan will pay a benefit for Travel Expenses and Lodging Expenses but only to the extent described below and only if charges incurred for the NME Procedures and Treatment Types are Covered Medical Expenses.

Any charges made by the NME facility for services and supplies which are:

- furnished in connection with any of the procedures or treatment listed below; and
- are included under this Plan as Covered Medical Expenses;

will be considered to be expenses incurred for Preferred Care.

#### ***NME Procedure and Treatment Types***

|                        |                            |
|------------------------|----------------------------|
| Heart transplant       | Heart/lung transplant      |
| Lung transplant        | Kidney transplant          |
| Liver transplant       | Pancreas transplant        |
| Bone marrow transplant | Kidney/pancreas transplant |

#### ***Travel Expenses***

These are expenses incurred by an **NME Patient**, and approved in advance by Aetna, for transportation between his or her home and the NME facility to receive services in connection with any listed procedure or treatment.

Also included are expenses incurred by a **Companion**, and approved in advance by Aetna, for transportation when traveling with an **NME Patient** between the **NME Patient's** home and the NME facility to receive such services.

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### ***Lodging Expenses***

These are expenses incurred by an **NME Patient**, and approved in advance by Aetna, for lodging away from home:

- while traveling between his or her home and the facility to receive services in connection with any listed procedure or treatment; or
- to receive outpatient services from the facility in connection with any listed procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per night.

Also included are expenses incurred by a **Companion**, and approved in advance by Aetna, for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per night.

For the purpose of determining Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the NME facility, or to which he or she travels at the end of a period of treatment, will be considered to be the **NME Patient's** home.

### ***Travel and Lodging Benefit Maximum***

For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:

one year after the day the procedure is performed; and

the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Benefits paid for Travel Expenses and Lodging Expenses do not count against any person's Maximum Benefit.

### ***Limitations***

Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

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## Explanation of Some Important Plan Provisions

### **Calendar Year Deductible**

This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person. An expense incurred in the last 3 months of a calendar year which is applied against a person's Calendar Year Deductible will reduce his or her Calendar Year Deductible for the next year.

### **Family Deductible Limit**

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

### **Hospital Emergency Room Deductible and Hospital Emergency Room Copay**

A separate Hospital Emergency Room Deductible or Copay applies to each visit for **emergency care**, by a person to a **hospital's** emergency room, unless the person is admitted to the **hospital** as an inpatient immediately following a visit to a **hospital** emergency room.

### **Lifetime Maximum Benefit**

This is the most that will be payable for any person in his or her lifetime. It will be restored each January 1 by the amount then charged against it. Not more than the Restoration Amount will be restored. It will not provide benefits for Covered Medical Expenses incurred before the date the Lifetime Maximum Benefit is restored.

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## Limitations

### **Preexisting Conditions**

A "preexisting condition" is an injury or disease for which a person:

received treatment or services; or  
took prescribed drugs or medicines;

during the 90 days right before the person's effective date of coverage (or, if the Plan requires you to serve a probationary period, the 90 days right before the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Summary of Coverage, whichever applies, to determine a person's effective date of coverage.

For the first 365 days following such date, Covered Medical Expenses incurred for treatment of a preexisting condition only include the first \$ 4,000 of Covered Medical Expenses for which no benefit is payable: under any other part of this Plan; or under any other group plan of your Employer.

### **Special Rules As To A Preexisting Condition**

If a person had creditable coverage and such coverage terminated within 90 days prior to the date he or she enrolled (or was enrolled) in this Plan, then any limitation as to a preexisting condition under this Plan will not apply for that person.

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Also, if a person enrolls (or is enrolled) in this Plan immediately after any applicable probationary period has been served, and that person had creditable coverage which terminated within 90 days prior to the first day of such probationary period, then any limitation as to a preexisting condition will not apply for that person.

As used above: "creditable coverage" means a person's prior medical coverage as defined in the Alaska Statutes 21.54.500 (7). Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

### **Routine Screening for Cancer**

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred for **physician** services and laboratory services; in giving, reviewing, interpreting, and reporting test results in connection with:

a routine mammogram;

a routine Pap smear each calendar year for a female age 18 or over; and

a routine prostate cancer screening test, consisting of a specific antigen blood test (or another test that is equivalent or better in cancer detection), for a male age 35 or over;

for routine screening for cancer.

### **Mouth, Jaws, and Teeth**

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, **physician** includes a **dentist**.

**Hospital** services and supplies received for an inpatient **hospital** confinement required because of the person's condition.

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

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Dental work, surgery, and **orthodontic treatment** needed to remove, repair, replace, restore, or reposition:

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

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

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only charges for:

- the first denture or fixed bridgework to replace lost teeth;
- the first crown needed to repair each damaged tooth; and
- an in-mouth appliance used in the first course of **orthodontic treatment** after the injury.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for tooth removal.

Not included are charges:

- to remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures, or bridgework;
- for periodontal treatment;
- for dental cleaning, in-mouth scaling, planing, or scraping;
- for myofunctional therapy; this is:
  - muscle training therapy; or
  - training to correct or control harmful habits.

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## **Emergency Room Treatment**

### *Emergency Care*

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Payment Percentage.

### *Non-Emergency Care*

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

No benefit will be paid under any other part of this Plan for charges made by a **hospital** for care in an emergency room that is not **emergency care**.

## **Certification For Hospital Admissions**

This certification section applies to admissions other than those for the treatment of alcoholism, drug abuse or **mental disorders**. A separate section applies to such admissions.

If:

- a person becomes confined in a **hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by a **physician** who is a **Preferred Care Provider**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:

If certification has been requested and denied:

No benefits will be paid for Hospital Expenses incurred for board and room.

Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

No benefits will be paid for Hospital Expenses incurred for board and room.

As to all other Hospital Expenses:

Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

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Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:

Hospital Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Hospital Expenses will be payable at the Payment Percentage.

- As to other Covered Medical Expenses:

Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied to expenses for **hospital** room and board.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician**, or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

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## Certification For Convalescent Facility Admissions, Home Health Care Expenses, Hospice Care Expenses, and Skilled Nursing Care

If a person incurs Covered Medical Expenses:

- while confined in a **convalescent facility** or a **hospice facility**; or
- for a service or a supply for home health care or hospice care while not confined as an inpatient or skilled nursing care; and

it has not been certified that:

- such confinement or any day of it is **necessary**; or
- such other services or supplies (either specifically or as a part of a planned program of care) are **necessary**, and
- the confinement or service or supply has not been ordered or prescribed by a **physician** who is a **Preferred Care Provider**;

such Covered Medical Expenses will be paid only as follows:

- As to Convalescent Facility Expenses and Hospice Care Facility Expenses incurred while confined in a **convalescent facility** or a **hospice facility**:

If certification has been requested and denied:

No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

Benefits for all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

As to all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:

Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses. Benefits for all other such expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement or (any day of such confinement) is **necessary**:

Convalescent Facility Expenses or Hospice Care Facility Expenses, incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other such expenses, incurred during the confinement, will be paid at the Payment Percentage.

As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.

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- As to Covered Medical Expenses incurred for services or supplies either as stated or as a part of a planned program of care for home health care, hospice care while not confined as an inpatient, or skilled nursing care:

If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not **necessary**, no benefits will be paid for the denied or unnecessary service or supply.

If certification has not been requested for a service or supply and the service or supply is **necessary**, benefits for the necessary service or supply will be paid as follows:

Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan; except that:

- To the extent that a day of confinement has been certified, the exclusion of services and supplies because they are not **necessary** will not apply to:

Convalescent Facility Expenses for room and board; or

Hospice Care Facility Expenses for room and board.

- To the extent that such service or supply has been certified for home health care, hospice care, or skilled nursing care, the exclusion of services or supplies because they are not **necessary** will not apply to such service or supply.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies.

Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If:

- services and supplies for hospice care provided to a person have been certified; and
- the person later requires confinement in a **hospital** for pain control or acute symptom management;

any other certification requirement in this plan will be waived for any such day of confinement in a **hospital**.

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## Certification For Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse or Mental Disorders

If, in connection with the **effective treatment of alcoholism or drug abuse** or treatment of **mental disorders**, a person incurs Covered Medical Expenses while confined in a **hospital** or **treatment facility**; and

- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by a **physician** who is a **Preferred Care Provider**:

Covered Medical Expenses incurred on any day not certified during the confinement will be paid only as follows:

With respect to expenses for **hospital** and **treatment facility** board and room:

If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not **necessary**, no benefits will be paid.

If certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

With respect to all other **hospital** and **treatment facility** expenses:

If certification has been requested and denied, or if certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement is not **necessary**, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not **necessary** will not be applied to **hospital** and **treatment facility** board and room.

To get the days certified, you must call the number shown on your ID card. Such certification must be obtained before confinement as a full-time inpatient, or in the case of an **emergency admission**, within 48 hours after the start of a confinement as a full-time inpatient or as soon as reasonably possible.

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

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## Treatment of Alcoholism or Drug Abuse

Certain expenses for the treatment shown below are Covered Medical Expenses.

### *Inpatient Treatment*

If a person is an inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

### *Hospital*

Expenses for the treatment of the medical complications of alcoholism or drug abuse are covered. This means things such as cirrhosis of the liver, delirium tremens or hepatitis.

### *Treatment Facility or Hospital*

Certain expenses for the treatment of alcoholism or drug abuse are covered if they are incurred during a full-time confinement. The expenses covered for those are:

Board and room. Not covered is any **charge for daily board and room** in a private room over the Private Room Limit.

Other **necessary** services and supplies.

### *Outpatient Treatment*

If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Expenses incurred for charges made by a **hospital** or **treatment facility** for the treatment of alcoholism or drug abuse are covered.

### *Calendar Year and Lifetime Maximums For Treatment of Alcoholism and Drug Abuse*

The maximum payable in a calendar year is the Special Inpatient and Outpatient Calendar Year Maximum. Not more than the Alcoholism and Drug Abuse Lifetime Maximum is payable under this Plan for all expenses incurred during his or her lifetime by a person for treatment of alcoholism and drug abuse.

## Treatment of Mental Disorders

Expenses for the treatment of a **mental disorder** are Covered Medical Expenses to the extent shown below.

If a person is a full-time inpatient in a hospital: A Special Inpatient Calendar Year Maximum Days applies for each person.

If a person is not a full-time inpatient in a **hospital**, the maximum benefit payable in a calendar year is the Special Outpatient Calendar Year Maximum Visits.

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# General Exclusions

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## General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those expenses incurred for or in connection with procedures; services; or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

if required by the 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, investigational, or for research purposes; or

the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

the disease can be expected to cause death within one year, in the absence of effective treatment; and

the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.

- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for services and supplies:

Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in your Booklet-Certificate.
- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet-Certificate.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.

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- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

Improve the function of a part of the body that:

is not a tooth or structure that supports the teeth; and

is malformed:

as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or

as a direct result of:

disease; or

surgery performed to treat a disease or injury.

Repair an injury. Surgery must be performed:

in the calendar year of the accident which causes the injury; or

in the next calendar year.

- Those to the extent they are not **recognized charges**, as determined by Aetna; except that this will not apply if the charge for a service or supply does not exceed the **recognized charge** for that service or supply by more than the amount or percentage specified in the Summary of Coverage as the Allowable Variation.
- Those for weight control services including: surgical procedures; medical treatments; weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications; food or food supplements; 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.
- Those for the reversal of a sterilization procedure.
- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

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# Effect of Benefits Under Other Plans

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## Coordination of Benefits - Other Plans Not Including Medicare

**Benefits Subject To This Provision:** This Coordination of Benefits (COB) provision applies to This Plan when an employee or the employee's covered dependent has medical and/or dental coverage under more than one Plan. "Plan" and "This Plan" are defined herein.

The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total **allowable expense**.

**Definitions.** When used in this provision, the following words and phrases have the meaning explained herein.

**Allowable Expense** means a health care service or expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room (unless the patient's stay in the private **hospital** room is medically **necessary** in terms of generally accepted medical practice, or one of the Plans routinely provides coverage of **hospital** private rooms) is not an allowable expense.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense, unless the secondary plan's provider's contract prohibits any billing in excess of the provider's agreed upon rates.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary Plan's payment arrangements shall be the allowable expense for all the Plans.

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5. The amount a benefit is reduced by the primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

**Claim Determination Period** means the Calendar Year.

**Closed Panel Plan.** A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

**Custodial Parent.** A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

**Plan.** Any Plan providing benefits or services by reason of medical or dental care or treatment, which benefits or services are provided by one of the following:

- A. Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- B. Other prepaid coverage under service plan contracts, or under group or individual practice;
- C. Uninsured arrangements of group or group-type coverage;
- D. Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
- E. Medical benefits coverage in a group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
- F. Medicare or other governmental benefits;
- G. Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

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

**Primary Plan/Secondary Plan.** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

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### Order Of Benefit Determination.

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

- A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- B. A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- D. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:
  - (1) **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
  - (2) **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:
    - (a) The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.
    - (b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

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- (c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
- The plan of the custodial parent;
  - The plan of the spouse of the custodial parent;
  - The plan of the noncustodial parent; and then
  - The plan of the spouse of the noncustodial parent.
- (3) **Active or Inactive Employee.** The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule labeled D(1).
- (4) **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (5) **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, subscriber longer is primary.
- (6) **If the preceding rules do not determine the primary plan,** the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

**Effect On Benefits Of This Plan.**

- A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:
- (1) Determine its obligation to pay or provide benefits under its contract;
  - (2) Determine whether a benefit reserve has been recorded for the covered person; and
  - (3) Determine whether there are any unpaid allowable expenses during that claims determination period.
- B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

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**Right To Receive And Release Needed Information.**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

**Facility Of Payment.**

Any payment made under another Plan may include an amount which should have been paid under This Plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

**Right of Recovery.**

If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

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## **Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage**

If you are in an Eligible Class and have chosen coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Health Expense Coverage (except Vision Care, if any) on the date of your coverage under such HMO Plan.

If you are in an Eligible Class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this Plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when Aetna gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when the Aetna gives its written consent.

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Any extensions of benefits under this Plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this Plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- the end of a 90 day period; and
- the date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

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## Effect of Medicare

The following provisions explain how the benefits under This Plan interacts with benefits available under Medicare.

**Medicare**, when used in this provision, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

A person is "**eligible for Medicare**" if he or she:

- is covered under it by reason of age, disability, or End Stage Renal Disease;
- is not covered under it because of:

having refused it;  
having dropped it; or  
having failed to make proper request for it.

If a person is eligible for Medicare, This Plan will pay for such benefits as for such person as the Primary Payor or Secondary Payor, as follows:

If your coverage for This Plan's benefits is based on current employment with the Employer, This Plan will act as the Primary Payor for the Medicare beneficiary who is eligible for Medicare:

- (a) solely due to age if this Plan is subject to the Social Security Act requirements for Medicare with respect to working aged (i.e., generally a plan of an employer with 20 or more employees).
- (b) due to end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits. But this does not apply if at the start of such eligibility the person was already eligible for Medicare benefits and this Plan's benefits were payable on a Secondary basis.
- (c) solely due to any disability other than end stage renal disease; but only if this plan meets the definition of a large group health plan in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

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Otherwise, This Plan will cover the benefits as the Secondary payor. This Plan will pay the difference between the benefits of this Plan and the benefits that Medicare pays, up to 100% of “Plan Expenses.” “Plan Expenses” means any **necessary** and reasonable health expenses, part or all of which is covered under this Plan.

Charges used to satisfy a person’s Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

Any rule for coordinating “other plan” benefits with those under this Plan will be applied after this Plan’s benefits have been figured under the above rules.

### **Exclusions**

Those charges for non-emergency care or treatment furnished by a covered person’s physician under a Private Contract are excluded. A Private Contract is a contract between a Medicare beneficiary and a **physician** who has decided not to provide services through Medicare.

This exclusion applies to services an “opt out” physician has agreed to perform under a Private Contract signed by the covered person. Physicians who have decided not to provide services through Medicare must file an “opt out” affidavit with all carriers who have jurisdiction over claims the physician would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into with a Medicare beneficiary.

### **Right to Receive and Release Needed Information.**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

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## **Effect of Prior Coverage - Transferred Business**

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

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# General Information About Your Coverage

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## Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- The last day of the month in which employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next premium due date following the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 30 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer, but not beyond the end of the policy month after the policy month in which the absence started. The term "policy month" is defined elsewhere in the group contract. See your Employer for this definition.

The Summary of Coverage may show an Eligible Class of retired employees. If you are in that class, your employment may be deemed to continue:

- for any coverage shown in the Retirement Eligibility section; and
- subject to any limits shown in that section.

If no Eligible Class of retired employees is shown, there is no coverage for retired employees.

In figuring when employment will stop for the purposes of termination of any coverage, Aetna will rely upon your Employer to notify Aetna. This can be done by telling Aetna or by stopping premium payments. Your employment may be deemed to continue beyond any limits shown above if Aetna and your Employer so agree in writing.

If you cease active work, ask your Employer if any coverage can be continued.

## Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

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## Handicapped Dependent Children

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued a personal medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age.

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## Health Expense Benefits After Termination

If a person is totally disabled when his or her Health Expense Coverage ceases, benefits will be available to such person while he or she continues to be totally disabled for up to the applicable period shown below, but, with respect to Medical Expense benefits, only as to expenses incurred in connection with the injury or disease that caused the total disability.

The words "totally disabled" mean that due to injury or disease:

- You are not able to engage in your customary occupation and are not working for pay or profit.
- Your dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

Medical Expense benefits will be available to him or her while disabled for up to 12 months.

Health Expense benefits will cease on the first to occur of the following:

- The person's Lifetime Maximum Benefit is paid.
- The person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.)

If this provision applies to you or one of your covered dependents, see the section Conversion of Medical Expense Coverage for information which may affect you.

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## Conversion of Medical Expense Coverage

If the state where you legally reside mandates that a personal policy be offered for conversion upon cessation of Medical Expense Coverage, regardless of where the group policy may be issued, this plan will permit certain persons whose Medical Expense Coverage has ceased to convert to a personal medical policy. No medical exam is needed. You and your family members may convert when all coverage ceases because your employment ceases or you cease to be in an eligible class. However, you and your family members may not convert if coverage ceases because the group contract has been discontinued as to your medical coverage.

The personal policy may cover:

- you only; or
- you and all of your family members who are covered under this Plan when your coverage ceases; or
- if you die before you retire, all your family members, or your spouse only, who are covered under this Plan when your coverage ceases.

Also, if your own coverage continues, your dependents can apply if they cease to be a dependent as defined in this Plan.

You may convert when you become a retired employee. If this Plan permits retired employees to continue Medical Expense Coverage, and you choose to do so, this conversion privilege will not again be available to you.

The personal policy must be applied for within 31 days after coverage ceases or would otherwise cease without a provision to continue coverage for retired employees. The 31 days start on the date coverage actually ceases even if the person is still eligible for benefits because the person is totally disabled.

Aetna may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:

any other hospital or surgical expense insurance policy;

any hospital service or medical expense indemnity corporation subscriber contract;

any other group contract;

any statute, welfare plan or program;

and that with the converted policy, would result in overinsurance or match benefits.

- The state where you legally reside does not require conversion if the person is or could be covered under Medicare (Title XVIII of the Social Security Act, as amended).

No one has the right to convert if you have been insured under this Plan for less than 3 months. Also, no person has the right to convert if:

- he or she has used up the maximum benefit; or
- he or she becomes eligible for any other Medical Expense Coverage under this Plan.

The personal policy form, and its terms, will be of a type, for group conversion purposes:

- as required by law or regulation; or
- as then offered by Aetna under your Employer's conversion plan.

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It will not provide coverage which is the same as coverage under this Plan. The level of coverage may be less and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both of:

- A statement that benefits under it will be cut back by any like benefits payable under this Plan after your coverage ceases.
- A statement that Aetna may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.

The personal policy will state that Aetna has the right to refuse renewal under some conditions. These will be shown in that policy.

If you or your dependent want to convert:

- Your Employer should be asked for a copy of the "Notice of Conversion Privilege and Request" form.
- Send the completed form to the address shown.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply.

The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be Aetna's normal rate for the person's class and age, and the form and amount of coverage.

The personal policy will take effect on the day after coverage terminates under this Plan.

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## Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

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## Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at Aetna's expense.

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## Legal Action

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

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## Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer or, if you prefer, from the Home Office of Aetna.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued with respect to all or any class of employees.

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## Assignments

Coverage may be assigned only with the written consent of Aetna.

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## Subrogation and Right of Reimbursement

If this Plan pays benefits under this Booklet-Certificate to a covered person for expenses incurred due to **third party injuries**, then Aetna retains the right to repayment of the full cost of all benefits provided by this Plan on behalf of the covered person that are associated with the **third party injuries**. Aetna's rights of recovery apply to any recoveries made by or on behalf of the covered person from the following sources, including but not limited to:

- payments made by a **third party** or any insurance company on behalf of the **third party**;
- any payments or awards under an uninsured or underinsured motorist coverage policy;
- any Workers' Compensation or disability award or settlement;
- medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- any other payments from a source intended to compensate a covered person for injuries resulting from an accident or alleged negligence.

By accepting benefits under this Plan, the covered person specifically acknowledges Aetna's right of subrogation. When this Plan pays health care benefits for expenses incurred due to **third party injuries**, Aetna shall be subrogated to the covered person's right of recovery against any party to the extent of the full cost of all benefits provided by this Plan. Aetna may proceed against any party with or without the covered person's consent.

By accepting benefits under this Plan, the covered person also specifically acknowledges Aetna's right of reimbursement. This right of reimbursement attaches when this Plan has paid health care benefits for expenses incurred due to **third party injuries** and the

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covered person or the covered person's representative has recovered any amounts from a **third party**. By providing any benefits under this Booklet-Certificate, Aetna is granted an assignment of the proceeds of any settlement, judgment or other payment received by the covered person to the extent of the full cost of all benefits provided by this Plan. Aetna's right of reimbursement is cumulative with and not exclusive of Aetna's subrogation right and Aetna may choose to exercise either or both rights of recovery.

By accepting benefits under this Plan, the covered person or the covered person's representatives further agree to:

- Notify Aetna promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to **third party injuries** sustained by the covered person;
- Cooperate with Aetna and do whatever is necessary to secure Aetna's rights of subrogation and reimbursement under this Booklet-Certificate;
- Give Aetna a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with **third party injuries** provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due Aetna as reimbursement for the full cost of all benefits associated with **third party injuries** paid by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by Aetna in writing;
- Do nothing to prejudice Aetna's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the Plan; and
- Serve as a constructive trustee for the benefits of this Plan over any settlement or recovery funds received as a result of **third party injuries**.

Aetna may recover full cost of all benefits paid by this Plan under this Booklet-Certificate without regard to any claim of fault on the part of the covered person, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from Aetna's recovery, and Aetna is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by the covered person to pursue the covered person's claim or lawsuit against any **third party** without the prior express written consent of Aetna. In the event the covered person or the covered person's representative fails to cooperate with Aetna, the covered person shall be responsible for all benefits paid by this Plan in addition to costs and attorney's fees incurred by Aetna in obtaining repayment.

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## Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, Aetna has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery Aetna may have with respect to such overpayment.

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## Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your Employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

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## Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received.

All benefits are payable to you. However, Aetna has the right to pay any health benefits to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.

Any unpaid balance will be paid within 30 days of receipt by Aetna of the due written proof.

Aetna may pay up to \$ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

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## Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **physicians, dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

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# Glossary

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The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

## **Board and Room Charges**

Charges made by an institution for board and room and other **necessary** services and supplies. They must be regularly made at a daily or weekly rate.

## **Body Mass Index:**

This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

## **Brand Name Drug**

A **prescription drug** which is protected by trademark registration

## **Companion**

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

## **Convalescent Facility**

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and

physical restoration services to help patients to meet a goal of self-care in daily living activities.

- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

## **Copay**

This is a fee, charged to a person, which represents a portion of the applicable expense. It is specified in the Summary of Coverage.

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As to a **prescription drug** dispensed by a **preferred pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is dispensed.

As to a **prescription drug** dispensed by a **non-preferred pharmacy**, this is the amount by which the total charge for the **prescription drug** is reduced before benefits are payable.

In no event will the copay be greater than the **prescription** or refill.

### **Custodial Care**

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

### **Dentist**

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

### **Directory**

This is a listing of all **Preferred Care Providers** for the class of employees of which you are a member. Copies of this Directory are given to your Employer to give to you. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at [www.aetna.com](http://www.aetna.com).

### **Durable Medical and Surgical Equipment**

This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

### **Emergency Admission**

One where the **physician** admits the person to the **hospital** or **treatment facility** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:

placing the person's health in serious jeopardy; or  
serious impairment to bodily function; or

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serious dysfunction of a body part or organ; or  
in the case of a pregnant woman, serious jeopardy to the health of the fetus.

### **Emergency Care**

This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

### **Emergency Condition**

This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

### **Generic Drug**

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

### **Home Health Care Agency**

This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or a **R.N.**; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

### **Home Health Care Plan**

This is a plan that provides for care and treatment of a disease or injury.  
The care and treatment must be:

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

### **Hospice Care**

This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

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## Hospice Care Agency

This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
  - skilled nursing services; and
  - medical social services; and
  - psychological and dietary counseling.
- Provides or arranges for other services which will include:
  - services of a **physician**; and
  - physical and occupational therapy; and
  - part-time home health aide services which mainly consist of caring for **terminally ill** persons; and
  - inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
  - one **physician**; and
  - one **R.N.**; and
  - one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- Assesses the patient's medical and social needs.
- Develops a **Hospice Care Program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

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## Hospice Care Program

This is a written plan of **Hospice Care**, which:

- Is established by and reviewed from time to time by:
  - a **physician** attending the person; and
  - appropriate personnel of a **Hospice Care Agency**.
- Is designed to provide:
  - palliative and supportive care to **terminally ill** persons; and
  - supportive care to their families.
- Includes:
  - an assessment of the person's medical and social needs; and
  - a description of the care to be given to meet those needs.

## Hospice Facility

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**; at least one such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a **R.N.**
- Has a full-time administrator.

## Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

## L.P.N.

This means a licensed practical nurse.

## Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail.

## Medication Formulary

A listing of **prescription drugs** which have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both **brand name drugs** and **generic drugs** and is subject to periodic review and modification by Aetna. See your Employer for a current listing.

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## **Mental Disorder**

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

## **NME Patient**

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

## **Necessary**

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, 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, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person 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, both as to the disease or injury involved and the person's overall health condition; 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 alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;

- 
- the opinion of health professionals in the generally recognized health specialty involved; and
  - any other relevant information brought to Aetna's attention.

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

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

### **Negotiated Charge**

This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

### **Non-Occupational Disease**

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

### **Non-Occupational Injury**

A non-occupational injury is an accidental bodily injury that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

### **Non-Preferred Care**

This is a health care service or supply furnished by a health care provider that is not a **Preferred Care Provider**; if, as determined by Aetna:

- the service or supply could have been provided by a **Preferred Care Provider**; and
- the provider is of a type that falls into one or more of the categories of providers listed in the **Directory**.

### **Non-Preferred Care Provider**

This is:

- a health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**; or
- a **Preferred Care Provider** that is furnishing services or supplies without the referral of a **Primary Care Physician**.

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### **Non-Preferred Pharmacy**

A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

### **Non-urgent Admission**

One which is not an **emergency admission** or an **urgent admission**.

### **Orthodontic Treatment**

This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

### **Other Health Care**

This is a health care service or supply that is neither **Preferred Care** nor **Non-Preferred Care**.

### **Pharmacy**

An establishment where **prescription drugs** are legally dispensed.

### **Physician**

This means a legally qualified physician.

### **Preferred Care**

This is a health care service or supply furnished by:

- a **Preferred Care Provider**; or
- a health care provider for an **emergency condition** when travel to a **Preferred Care Provider** is not feasible; or
- a Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible.

### **Preferred Care Provider**

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

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### **Preferred Pharmacy**

A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

### **Prescriber**

Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

### **Prescription**

An order of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

### **Prescription Drugs**

Any of the following:

- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

### **Psychiatric Physician**

This is a **physician** who:

- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

### **R.N.**

This means a registered nurse.

### **Recognized Charge**

Only that part of a charge which is recognized is covered. The recognized charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the Recognized Charge Percentage made for that service or supply.

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In determining the recognized charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the recognized charge in other areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

### **Semiprivate Rate**

This is the **charge for board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

### **Third Party**

As used in the Subrogation and Right of Reimbursement provision, this means any party that is, or may be, or is claimed to be responsible for injuries or illness to a covered person. The term includes any party responsible for payment of expenses associated with the care or treatment of **third party injuries**.

### **Third Party Injuries**

This means injuries or illness to a covered person for which a **third party** is, or may be, or is claimed to be responsible.

### **Terminally Ill**

This is a medical prognosis of 6 months or less to live.

### **Treatment Facility (Mental Disorder)**

This is an institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time **R.N.**

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- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
  - Makes charges.
  - Meets licensing standards.

### **Treatment of Alcoholism Or Drug Abuse**

Treatment mainly for maintenance care is not considered treatment of alcoholism or drug abuse. Maintenance care means providing an environment free of alcohol or drugs.

### **Urgent Admission**

One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

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## Confidentiality Notice

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

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

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at [www.aetna.com](http://www.aetna.com).

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## Continuation Coverage Rights Under COBRA

### Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

### What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

If your employer offers Retiree coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to "PH Name", and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's

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spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### **When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

### **You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

### **How is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

#### ***Disability extension of 18-month period of continuation coverage***

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to qualify for this extension you must provide a copy of your Disability Award letter that is received from the Social Security Administration prior to the end of your COBRA continuation period to the Plan administrator.

#### ***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the

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employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

### **If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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## **Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law**

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses will be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

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## Additional Information

### Retrospective Record Review

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of healthcare services. Aetna's effort to manage the services provided to members includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

### Concurrent Review and Discharge Planning

The following items apply if the Plan requires certification of any confinement, services, supplies, procedures, or treatments:

#### *Concurrent Review*

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.

#### *Discharge Planning*

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

### Provider Networks

If plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers from Anchorage School District, or by calling the toll - free Member Services number on your ID Card. A current list of providers in the Aetna network is available through DocFind®, at [www.aetna.com](http://www.aetna.com).