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Summary of Coverage
PPO Plan

Employer: United Nations

Administrative Services Contract Number: 014008

Effective Date: July 1, 2000

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

Comprehensive Medical Expense Coverage

All maximums included in this Plan are combined maximums between Preferred Care and Non-Preferred Care, where applicable, unless specifically stated otherwise.

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge."

If any expense is covered under one type of Covered Medical expense, it cannot be covered under any other type.

Retirees not enrolled in Medicare Part B

Deductible and Copayment (Copay) Amounts

Copayment (Copay):
This is a flat amount payable by the participant toward the cost of a Preferred (Network) medical visit or the dispensing of prescription drugs. Such Copayments do not count towards fulfilment of the annual coinsurance limit ($1,000/$3,000).

Deductible:
This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is an Individual Calendar Year Deductible that applies to each person.

Individual Calendar Year Deductible $ 125

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

Family Deductible Limit	$ 375

Retirees enrolled in Medicare Part B

In addition to the benefits of Aetna Open Choice described in this Plan Description, special provisions are extended to former staff members enrolled in Medicare Part B.

- Copays are waived for in-network services, such as office visits.
- Prescriptions filled at a participating pharmacy are paid at 100%; copays are waived. Prescriptions filled at a non-participating pharmacy are reimbursed at 80%, with no deductible.
- The calendar year deductible will continue to be waived for all non-network services.

Please note: Eligibility for these special provisions is based solely on the Medicare status of the subscriber, and is shown on the special Aetna ID card for Medicare Part B enrollees. When a subscriber is enrolled in Medicare Part B, the above provisions will apply to all covered family members, regardless of whether or not they are enrolled in Medicare. When the subscriber is not enrolled in Medicare Part B, the above provisions do not apply, even if a covered family member is enrolled in Medicare.

Summary of Coverage

The Payment Percentage applies after any deductible or copay amounts.

	Preferred Care (Network Care)	Non-Preferred Care (Non-Network Care)
Deductible		
Individual	*0*	*$125*
Family	*0*	*$375*
Coinsurance (Payment) Limit		
Individual	*$1,000*	
Family	*$3,000*	
(network and prescription drug copays do not count toward the coinsurance (payment) limit)		
Lifetime Maximum	*Unlimited*	*Unlimited*
Preventive Care		
Routine Physicals and Immunizations Children age 19+ and adults: one routine exam every 24 months. Age 65+: one routine exam every 12 months	*100% after a $ 10 copay*	*80% after deductible*
Well-Child Care and Immunizations Well-child care to age 7. One exam every 24 months for ages 7 to 19	*100%*	*100%*
Routine Ob/Gyn Exam One routine exam per calendar year, including one Pap smear and related fees	*100% after a $ 10 copay*	*80% after deductible*
Routine Mammogram (no age limit)	*100%*	*80% after deductible 100% if performed on an in-patient basis or in the out-patient department of a hospital*
Routine Eye Exam(One every 12 months)	*100% after a $ 10 copay*	*80% after deductible*
Vision Care		
Optical Lenses (including contact lenses)	*80%, deductible does not apply; $100 maximum for any two lenses purchased in a 12 month period*	

	Preferred Care (Network Care)	Non-Preferred Care (Non-Network Care)
Preventive Care (continued) *Vision One Program*	*Save up to 65% on frames; up to 50% on lenses; about 20% on contact lenses at participating Cole Vision Centers*	
Hearing Exam	*100% after a $ 10 copay*	*$100 maximum benefit; one exam every three years; exam must be performed by otolaryngologist or state certified audiologist*
Hearing Device[1]	80%, deductible does not apply; *$750 maximum benefit, one hearing aid per ear every three years*	
Physicians Services *(excluding mental health and substance abuse treatment)*		
Office Visits for treatment of illness or injury (non-surgical)	*100% after a $ 10 copay*	*80% after deductible*
Maternity (includes voluntary sterilization and voluntary abortion)	*100% after a $ 10 copay*	*80% after deductible*
Physician In-Hospital Services	*100%*	*80% after deductible*
Specialists (office visits)	*100% after a $ 10 copay*	*80% after deductible*
Surgery	*100%*	*80% after deductible*

[1]*There are no network providers for these services at the present time.*

	Preferred Care (Network Care)	Non-Preferred Care (Non-Network Care)
Physicians Services (continued)		
Second Surgical Opinion (not required)	*100% after a $ 10 copay*	*100% after deductible*
Allergy Testing and Treatment (given by a physician)	*100% after a $ 10 copay*	*80% after deductible*
Allergy Injections (not given by a physician)	*100%*	*80% after deductible*
Other Physician Services	*100%*	*80% after deductible*
Hospital Services		
In-patient Coverage (semi-private accommodation)	*100%*	*100%*
Out-patient Coverage	*100%*	*100%*
Emergency Care		
Hospital Emergency Room Based on symptoms. Covers sickness within 12 hours onset; surgery; accident within 72 hours	*100% after a $35 copay* *(copay is waived if confined)*	*100% after a $35 deductible* *(deductible is waived if confined)*
Hospital Emergency Room for non-emergency care (examples of conditions: skin rash, ear ache, bronchitis, etc.)	*80%*	*80% after deductible*
Ambulance[1]	100%	
Health Care Alternatives		
Skilled Nursing Facility up to 365 days per calendar year	100%	

[1]*There are no network providers for these services at the present time.*

	Preferred Care (Network Care)	Non-Preferred Care (Non-Network Care)
Health Care Alternatives (continued)		
Home Health Care (no prior confinement required)	*100% (200 visits per calendar year)*	*100% (200 visits per calendar year)*
Private Duty Nursing *Restricted benefit on an in-patient basis* *Calendar Year Maximum:$5,000* *Lifetime Maximum:$10,000*	*100%* *up to 70 eight-hour shifts per calendar year*	*80% after deductible* *up to 70 eight-hour shifts per calendar year*
Hospice *In-patient and Out-patient Coverage*	*100%* *up to 210 days for both in-patient and out-patient services*	
Bereavement Counseling	*100%, up to 5 visits*	
Pre-certification *Applies to in-patient hospital, skilled nursing facility, home health care, hospice care, and private duty nursing care*	*Provider responsible*	*Not required*
Other Health Care *Short-Term Rehabilitation* *Physical and Occupational Therapy*	*100%*	*80% after deductible*
Speech Therapy	*80%, deductible does not apply* *(where services are rendered by a participating provider, 100% reimbursement applies after a $10 copay)*	
Out-patient Diabetic Self-Management Education Program	*80%, deductible does not apply*[1]	
Durable Medical Equipment	*80%, deductible does not apply*[2]	

[1]If services are rendered in a hospital, 100% reimbursement applies with no copay. If rendered in a network doctor's office, 100% reimbursement with a $10 copay applies.
[2]If services are rendered by a network provider or within a hospital setting, 100% reimbursement applies with no copay.

	Preferred Care (Network Care)	Non-Preferred Care (Non-Network Care)
Other Health Care(continued)		
Acupuncture[3] *(for chronic pain treatment only; services must be rendered by a medical doctor or licensed acupuncturist)*	*100% after a $ 10 copay up to a maximum benefit of $1,000*	*80% after deductible up to a maximum benefit of $1,000*
Spinal Manipulation[3]	*100% after a $ 10 copay up to a maximum benefit of $1,000*	*80% after deductible up to a maximum benefit of $1,000*
Prescription Drug Benefits		
Retail Program (covers viagra up to 6 tablets per month)	*100% after a $ 15 copay up to a 30-day supply at participating pharmacies; copay maximum is $15*	*60% after deductible*
Mail Order Program	*100% after a $ 10 copay for up to a 90-day supply from participating mail order vendor; when brand name is requested by you, you pay the copay plus the difference between the brand and generic price, unless the physician specifically prescribes the brand-name drug.*	

[3]Network and non-network benefits are combined for a maximum of $1,000 per calendar year.

Mental Health and Alcohol/Drug Abuse Services

These services are provided under the Focused Psychiatric Review (FPR) programme. Pre-certification of in-patient confinements are required. For in-network services, the network provider is responsible for pre-certification. For non-network services, either the **physician** or the **Staff Member** must pre-certify the confinement.[4]

	Preferred Care (Network Care)	**Non-Preferred Care (Non-Network Care)**
Mental Health Services[4]		
In-patient Coverage	*100%* *Maximum benefit of* *90 days per calendar year*	*100% after deductible* *Maximum benefit of* *90 days per calendar year*
Out-patient Coverage	*100%* *up to 50 visits per calendar year*	*80% after deductible* *up to 50 visits per calendar year*
Crisis Intervention	*100%* *up to 3 visits per calendar year*	*80% after deductible* *up to 3 visits per calendar year*
Alcohol/Drug Abuse[4]		
In-patient Coverage	*100%* *up to 60 days per calendar year*	*100% after deductible* *up to 60 days per calendar year*
Lifetime Maximum Benefit	*two confinements*	*two confinements*
Out-patient Coverage	*100%* *up to 60 visits per calendar year (includes 20 visits for counseling)*	*80% after deductible* *up to 60 visits per calendar year(includes 20 visits for counseling)*

[4]All benefit maximums are combined for network and non-network services.

Payment Limits

Payment Limit which Applies to Expenses for an Individual

When an individual's Coinsurance Outlays reach $ 1,000 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Payment Limit which Applies to Expenses for a Family

When a family's Coinsurance Outlays reach $ 3,000, in a calendar year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

These Payment Limits do not apply to these type of expenses:

- those normally payable at a rate of 50%;
- those payable at a reduced rate because of a failure to obtain any necessary certification;
- deductible or copay amounts;
- any expenses that Aetna has determined are not reasonable.

Benefit Maximums

(Read the coverage section in your Booklet for a complete description of the benefits available.)

Private Room Limit	The institution's semiprivate rate.

Lifetime Maximum Benefit: There is no Lifetime Maximum Benefit (overall limit) that applies to the Comprehensive Medical benefits described in the Booklet. The only maximum benefit limits are those specifically mentioned in your Booklet.

Claim Procedures

Your booklet contains information on reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

You may request a review of the denied claim. The request must be submitted, in writing, to the Plan Administrator within 60 days after you receive the notice. Include your reasons for requesting the review.
Your claim will be reviewed and ordinarily you will be notified of the final decision within 60 days of receipt of your request. If special circumstances require an extension of time, you will be notified of such extension during the 60 days following receipt of your request.

Late Enrollee

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within 31 days of the date the person becomes eligible for such coverage.

Enrollment Procedure

You may elect coverage for a Late Enrollee only during the annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollee will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for the Late Enrollee.

Exceptions

A person will not be considered to be a Late Enrollee if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:

  the person was covered under other "creditable coverage" as defined below; and

  you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
- the person loses such coverage because:

  of termination of employment in a class eligible for such coverage;

  of reduction in hours of employment;

  your spouse dies;

  you and your spouse divorce or are legally separated;

  such coverage was COBRA continuation and such continuation was exhausted; or

  the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes 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.

If you are not considered a Late Enrollee, Health Expense Coverage will become effective on the date of the election.

Additional Exceptions
Also, a person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A spouse or child who meets the definition of a dependent, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.
- Yourself and your spouse and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective; provided you make written request for such coverage within 31 days of the court order. Coverage for the child will become effective on the date of such court order. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Recognized Charge Percentage: The charge determined by Aetna on an annual basis to be in the 95th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished.

Allowable Variation None

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

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

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on the back of your ID card.

The Plan described in the following pages of this Booklet is a benefit plan of the United Nations and is administered by Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds provided by the United Nations and the contributions of its members.

Booklet Base: 2
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Health Expense Coverage

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.

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

Comprehensive Medical Expense Coverage

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

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

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

Not included is any **charge** for daily **room and board** in a private room over the semiprivate 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. The confinement must start during a "Convalescent Period".

- Room and board. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **room and board** in a private room over the semiprivate 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 **physicians** services.
- Medical supplies.

Benefits will be paid for up to the maximum number of days during any one Convalescent Period. This starts on the first day a person is confined in a **convalescent facility** if he or she:

- was confined in a **hospital** for at least 3 days in a row, while covered under this Plan, for treatment of a disease or injury; and
- is confined in the facility within 14 days after discharge from the **hospital**; and
- is confined in the facility for services needed to convalesce from the condition that caused the **hospital** stay. These include skilled nursing and physical restorative services.

It ends when the person has not been confined in a **hospital**, **convalescent facility**, or other place giving nursing care for 90 days in a row.

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 given or supervised by an **R.N.**
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy from a **home health care agency**.
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or skilled nursing facility as defined in Title XVIII of the Social Security Act:

  medical supplies;

  drugs and medications 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 4 hours of home health aide services is one visit. (After the first 40 visits in a calendar year, 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.
- Transportation.
- Custodial care.
- Services or supplies given while the person is not under the care of a **physician**.

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:

- Room and board 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 **room and board** in a private room over the semiprivate 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.
- 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 more than the Maximum Number of Days for both inpatient and outpatient services will be paid for all Hospice Care Expenses.

Also included are:

- charges incurred for the first 5 visits for bereavement counseling given to members of the person's family. The counseling must be directly related to the person's death.

Not included are charges made:

- For bereavement counseling in excess of the first 5 visits.
- 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.

Preventive Health Care Services Expenses

The charges below are included as Covered Medical Expenses even though they are not incurred in connection with an injury or disease.

Preventive Health Care Services Expenses: These are the charges incurred for Preventive Health Care Services.

Preventive Health Care Services: These are services provided for a routine physical exam of a dependent child under 19 years of age. A routine physical exam is a medical exam given for a reason other than to diagnose or treat a suspected injury or disease. An exam includes:

- A review and written record of the child's complete medical history.
- Taking measurements and blood pressure.
- Anticipatory guidance.
- Developmental and behavioral assessment.
- Vision screening.
- Hearing screening.
- Other diagnostic screening tests. This includes:

  one series of hereditary and metabolic tests performed at birth: and

  urinalysis and blood tests; (such as hematocrit and hemoglobin tests).
- Immunizations for infectious disease at the frequency set forth in the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatricians.
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered Medical Expenses will not include charges incurred for Preventive Health Care Services for:

- More than 6 exams in the first year of the child's life.
- More than 2 exams in the second year of the child's life.
- More than one exam per year during the next 4 years of the child's life.
- More than one exam every 24 months thereafter.

Not covered as Preventive Health Care Services Expenses are charges incurred for:

- services which are covered to any extent under any other:

  part of this Plan;

  group plan sponsored by your Employer;
- services which are for: diagnosis; or treatment; of a suspected or identified injury or disease;
- services not performed by or under the direct supervision of: a **physician**; **R.N.**; **L.P.N.**; or nurse practitioner whose scope of practice includes the authority to provide the specified services;
- medicines or drugs;
- appliances, equipment or supplies;
- dental exams;
- vision exams;
- hearing exams;
- exams related in any way to employment;
- pre-marital exams.

Routine Physical Exams

The charges made by a **physician** for a routine physical exam given to you, your spouse, or your dependent child age 19 and older 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 age 19 and over, Covered Medical Expenses will not include charges for more than one exam in 24 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.

Routine Eye Exam Expenses

Covered Medical Expenses include charges for a complete eye exam, including refraction, which is furnished by a legally qualified ophthalmologist or optometrist to a person.

Covered Medical Expenses will not include charges for more than one eye exam in 12 months in a row.

Not included are charges for:

- any eye exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any services or supplies which are included as covered expenses under any other benefit section included in this Plan or under any other plan of group benefits provided through your Employer;
- any services or supplies for which benefits are provided under any workers' compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges;
- any service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a **hospital** or other facility for medical care;
- any eye exam required by an employer as a condition of employment, or an employer is required to provide under a labor agreement or is required by any law of a government.

Spinal Disorder Treatment

There is a calendar year benefit maximum which applies to Covered Medical Expenses incurred for:

- manipulative (adjustive) treatment; or
- other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Disorder Treatment Calendar Year Maximum will be payable in any one calendar year for all expenses in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating **physician**.

Acupuncture Expenses

Charges made for acupuncture services furnished to a person are included as Covered Medical Expenses if they are furnished by:

a **physician**; or

an **acupuncturist** certified by the American Association for Acupuncture and Oriental Medicine who is practicing within the laws of the jurisdiction where treatment is given:

and the service is given as a form of anesthesia in connection with surgery that is covered under this Plan to treat a disease or injury or to alleviate chronic pain.

For Covered Medical Expenses incurred, the benefit rate is the Payment Percentage. An Acupuncture Treatment Calendar Year Maximum applies each year for each person.

Short-Term Rehabilitation Expenses

The charges made by:

- a **physician**; or
- a licensed or certified physical, occupational or speech therapist;

for the following services for treatment of acute conditions are Covered Medical Expenses.

Short-term rehabilitation is therapy which is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to:

- an injury;
- a disease; or
- congenital defect.

Short-term rehabilitation services consist of:

- physical therapy;
- occupational therapy; or
- speech therapy,

furnished to a person who is not confined as an inpatient in a **hospital** or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

The charges for Short-Term Rehabilitation services are Covered Medical Expenses for no longer than the Short-Term Rehabilitation Maximum Days for each person during any one calendar year.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Plan.
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an Employer.
- Services received while the person is confined in a **hospital** or other facility for medical care.
- Services not performed by a **physician** or under his direct supervision.
- Services rendered by a physical, occupational or speech therapist who resides in the person's home, or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from:

  disease;

  injury; or

  congenital defect.
- Special education including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired, to function without that ability.

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:

- Details the treatment to be rendered and the frequency and duration of the treatment.
- Provides for ongoing reviews and is renewed only if therapy is still necessary.

Hearing Care Expenses

Covered Medical Expenses include charges for hearing care for the following services and supplies:

An audiometric exam and evaluation for a hearing aid prescription performed by:

a **physician** certified as an otolaryngologist or otologist; or

an audiologist who either:

is legally qualified in audiology; or

holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and

who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

An electronic hearing aid, installed in accordance with a prescription written during a covered hearing exam above.

If an eyeglass type hearing aid is installed, Covered Hearing Care Expenses will not exceed the reasonable charges for a conventional hearing aid of similar capability.

Covered Hearing Care Expenses will not include, during any one period of 36 continuous months:

Charges for more than one audiometric exam,; nor exam charges in excess of the Evaluation and Audiometric Exam Maximum; or

Charges for more than one hearing aid per ear; nor hearing aid charges in excess of the Hearing Device Maximum.

Not included are charges for:

- any ear or hearing exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- any hearing care service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a **hospital** or other facility for medical care; or
- any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government.

Optical Lens Expenses

Lenses prescribed for the first time and new lenses required due to a change in prescription. If contact lenses are prescribed, charges for them will also be covered.

Not more than a maximum of $100 for any 2 lenses will be deemed to be Covered Optical Lens Expenses in any one period of 24 months in a row.

Limitations

The following limitations apply.

No benefits will be payable for a charge which is:

- For a vision care supply which is a covered expense in whole or in part:

  under any other part of this Plan; or

  under any other plan of group benefits provided through your Employer.
- For a vision care supply for which a benefit is provided in whole or in part under any workers' compensation law or any other law of like purpose.
- For special supplies. This means things such as nonprescription sunglasses and subnormal vision aids
- For anti-reflective coatings.
- For tinting.
- For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
- For replacement of lenses that are lost, stolen or broken.

- For duplicate or spare eyeglasses or lenses for them.
- For a supply received while the person is not covered.
- For lenses furnished or ordered because of an eye exam that was done before the date the person becomes covered.

Other Medical Expenses

Nursing Services

- 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.**

Durable Medical and Surgical Equipment

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.

Other Medical

- 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.

Artificial limbs and eyes. Not included are such things as: eyeglasses; vision aids; hearing aids; communication aids; and orthopedic shoes, foot orthotics, or other devices to support the feet.

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.

Routine Mammogram and Pap Smear

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred:

- for routine screening by mammography for the presence of occult breast cancer in a female; and
- in connection with one routine Pap smear each calendar year for a female 18 years of age and over.

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**.

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out:

  Teeth partly or completely impacted in the bone of the jaw.

  Teeth that will not erupt through the gum.

  Other teeth that cannot be removed without cutting into bone.

  The roots of a tooth without removing the entire tooth.

  Cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- 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.

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

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.

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 including Temporomandibular Jaw Joint Disorder; whether or not the purposes of such services or supplies is to relieve pain;
- for root canal therapy;
- for routine tooth removal (not needing cutting of bone).

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 non-surgical periodontal treatment;
- for in-mouth scaling, dental cleaning, planing or scraping;
- for myofunctional therapy; this is:

  muscle training therapy; or

  training to correct or control harmful habits.

Treatment of Alcoholism or Drug Abuse

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

Inpatient Treatment

If a person is a full-time inpatient either:

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

then the coverage is as shown below.

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens or hepatitis.
- **Effective treatment of alcoholism or drug abuse**.
- Room and board. Not covered is any **charge for daily room and board** in a private room over the semiprivate room limit.
- Other **necessary** services and supplies.

Expenses are covered for the **effective treatment of alcoholism or drug abuse** but only if such expenses are incurred during the first 60 days of all such confinements during any one calendar year.

There is a Lifetime maximum of two confinements for the **effective treatment of alcoholism or drug abuse**.

Outpatient Treatment

Expenses incurred for the **effective treatment of alcoholism or drug abuse** while the person is not confined as a full-time inpatient in a **hospital** or **treatment facility** will be considered Covered Medical Expenses and will be payable at the Payment Percentage.

Benefits will not be paid for more than the Maximum Visits for Outpatient Coverage in any one calendar year. Such Maximum Visits will be reduced by each Counseling Maximum Visit which is included as Covered Medical Expenses during the same calendar year. Expenses which are incurred in a **treatment facility** are included to the same extent as if they were incurred in a **hospital**.

Also included as Covered Medical Expenses are counseling expenses incurred by a person covered under this Plan. They must be directly related to the person's alcoholism or drug abuse. Benefits will not be paid for more than the Counseling Maximum Visits in each calendar year.

Treatment of Mental Disorders

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

Inpatient Treatment

If a person is a full-time inpatient in a **hospital**: These expenses are covered but only if incurred during the first 90 days of confinement in any one calendar year.

Outpatient Treatment

If a person is not a full-time inpatient in a **hospital**: These expenses are covered as follows:

- For crisis intervention services:

  Benefits will not be paid for more than the Maximum Visits in any one calendar year.

  Crisis intervention services are services rendered in connection with an unforeseen clinical condition which requires prompt action since without prompt action:

  the person may be at risk of injuring him or herself or others; or

  the person is at risk of substantially deteriorating in ability to perform.
- For any other Covered Medical Expenses incurred, the benefit rate is the Payment Percentage. The most that will be paid for any one person in any one calendar year is the Maximum for Outpatient Coverage.

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, fees and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet.

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

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** and fee per **prescription** or refill

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.

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.

In figuring the benefit amount, a Separate Brand Name Fee applies to **brand name drugs** dispensed by a **mail order pharmacy** in addition to any applicable **copay**. The amount of the Separate Brand Name Fee will be equal to the difference between the cost of the **brand name drug** and the generic equivalent. The Separate Brand Name Fee will apply to any **brand name drug** dispensed unless:

- there is no generic equivalent to the **brand name drug**;
- the **mail order pharmacy** is unable to supply the **generic drug** at the time the **prescription** is presented; or
- the **prescriber** indicates that the **generic drug** should not be dispensed.

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.

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:

  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 if it 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 on an inpatient or 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 **prescription drug** also obtainable without a **prescription** on an "over the counter" basis.
- For immunization agents.
- For biological sera and blood products.
- For nutritional supplements.
- For any contraceptive drugs.
- For any smoking cessation aids or drugs.
- For appetite suppressants.
- For more than 6 unit doses per 30 day supply for the following drugs used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy:

  sildenafil citrate;
  phentolamine;
  apomorphine;
  alprostadil; or
  any other **prescription drug** that

  is in a similar or identical class,
  has a similar or identical mode of action or exhibits similar or identical outcomes.

  This limitation applies whether or not the **prescription drug** is delivered in oral, injectable, or topical (including, but not limited to, gels, creams, ointments, and patches) forms. If the drug is not taken orally, the dosage covered will be determined by Aetna based on the comparable cost for a 30 day supply of pills.
- For any drug dispensed by a **mail order pharmacy** for use for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

General Exclusions

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, as applicable**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, and approved by the person's attending **physician**.
- Those for or in connection with 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 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 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**.
- 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 does not include a plan established by a 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 or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- 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;

  is malformed:

  as a result of a severe birth defect; this includes harelip or webbed fingers or toes;

  as a direct result of:

  disease; or

  surgery performed to treat a disease or injury.

  Repair an injury which occurs while the person is covered under this Plan. Surgery must be performed:

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

  in the next calendar year.
- Those that are for therapy, or for supplies, or for 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.

- Those for the reversal of a sterilization procedure.
- Those for routine dental exams or other preventive services and supplies.
- Those for routine physical exams, routine vision exams, routine hearing exams or immunizations except as shown on pages 20 and 23.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- 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.

Any exclusion above will not apply to the extent that:

- coverage is specifically provided by name in your Booklet; or
- coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when determining 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.

Effect of Benefits Under Other Plans

Co-Ordination of Benefits

Some persons have health coverage in addition to coverage under this Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a calendar year, this Plan will pay:

- its regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract B. from A. below:

  A. 100% of "Allowable Expenses" incurred by the person for whom claim is made.
  B. The benefits payable by the "other plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any **necessary** and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made.

The difference between the cost of a private **hospital** room and the **semiprivate rate** is not considered an Allowable Expense under the above definition unless the patient's stay in a private **hospital** room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a United States Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, 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;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

      If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

Aetna has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Effect of Medicare

Health Expense Coverage will be changed for any person while covered under Medicare.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are calculated.
- 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. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

General Information About Your Coverage

Termination of Coverage

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

- When the group contract terminates as to the coverage.
- When Aetna receives notice from your Employer.
- When you fail to make any required contribution.

If your coverage ceases for any reason, contact your Employer immediately to find out what rights you may have under this Plan.

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 a member.
- When such person is no longer a defined dependent.
- When your coverage terminates.

Conversion of Medical Expense Coverage

This Plan permits 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. You may not convert if coverage ceases because the group contract has 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 member. If this Plan permits retired members 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 45 days after coverage ceases or would otherwise cease without a provision to continue coverage for retired members. The 45 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.

No one has the right to convert if you have been covered 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.

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.

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.

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, this Plan 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 this Plan may have with respect to such overpayment.

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.

Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the date on which medical services were rendered.

No legal action can be brought to recover under any benefit after 5 years from the date of occurrence.

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.

Payment of Benefits

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

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.

Pre-existing Conditions

Aetna will not reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect. This provision will not apply to conditions excluded from coverage on the date of the loss.

Glossary

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.

Brand Name Drug

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

Room and Board Charges

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

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 flat amount payable by the participant toward the cost of a **Preferred (Network)** medical visit or the dispensing of **prescription drugs**. Such Copayments do not count towards fulfilment of the annual coinsurance limit ($1,000/$3,000).

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 room and board 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.

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 person's 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.

Effective Treatment of A Mental Disorder
This a program that:

- is prescribed and supervised by a **physician**; and
- is for a disorder that can be favorably changed.

Effective Treatment of Alcoholism Or Drug Abuse
This means treatment of alcoholism or drug abuse in accord with a treatment plan given to Aetna by:

- a **physician**;
- a **hospital**; or
- a **treatment facility**.

The plan must be approved by Aetna.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of drinking or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

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

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

  loss of life or limb; or
  significant impairment to bodily function; or

  permanent dysfunction of a body part.

Emergency Care

This means the first treatment given in a **hospital's** emergency room right after the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition which:

- requires **hospital** level care because:

  the care could not safely and adequately have been provided other than in a **hospital**; or

  adequate care was not available elsewhere in the area at the time and place it was needed; and
- if the **hospital** level care was not given could, as determined by Aetna, reasonably be expected to result in:

  loss of life or limb; or

  significant impairment to bodily function; or

  permanent dysfunction of a body part.

Emergency Condition

This means the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition which, if the procedure or treatment was not performed right away could, as determined by Aetna, reasonably be expected to result in:

- loss of life or limb; or
- significant impairment to bodily function; or
- permanent dysfunction of a body part.

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**.

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.

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.

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.

Medically Necessary

A service or supply furnished by a particular provider is medically 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(Non-Network 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 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 Resulting From Injury or Disease

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.

Pharmacy

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

Physician
This means a legally qualified physician.

Preferred Care(Network Care)
This is a health care service or supply furnished by:

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

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, or compounded **prescription** 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 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. However, they do not include:

  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.
- disposable diabetic supplies.
- disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.

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.

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.

Semiprivate Rate

This is the **charge** for **room and board** 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.

Terminally Ill

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

Treatment Facility (Alcoholism Or Drug Abuse)

This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **effective treatment of alcoholism or drug abuse**.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician**.
- Provides, on the premises, 24 hours a day:

  Detoxification services needed with its effective treatment program.

  Infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.

  Supervision by a staff of **physicians**.

  Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

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.**
- 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.

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.