

# Appendix A – Amendment 7

## Amendment to Plan of Benefits

**For Employees of:** The Dow Chemical Company  
**Administrative Services Agreement No.:** 783135

Effective April 1, 2014, the following changes have been made to your Booklet.

The *Accessing Providers and Benefits* section has been changed by the addition of the following:

Your Dow Chemical Company medical plan will no longer pay for services received at certain facilities.

These facilities are:

- The Houston Center for Outpatient Surgery
- Physicians Surgicenter of Houston
- St. Michaels Center for Special Surgery
- Center for Minimally Invasive Surgery, LLC

This means that there is no coverage for both:

- health care services provided by these facilities, and
- health care services provided by physicians and other health care professionals at these facilities.

Effective April 1, 2014, if you use any of these facilities for any service you will be responsible for the full cost of services.

## Appendix A

# BENEFIT PLAN

Prepared Exclusively for  
THE DOW CHEMICAL COMPANY

Traditional Choice – Over Age 65  
Retirees – Comprehensive Medical  
Old & New Plans Only

What Your Plan  
Covers and How  
Benefits are Paid

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\*Defines the Terms Shown in Bold Type in the Text of This Document.

# Schedule of Benefits

**Employer:** The Dow Chemical Company

**ASA:** 783135

**Issue Date:** September 20, 2013

**Effective Date:** January 1, 2014

**Schedule:** 119A

**Booklet Base:** 119

For: Traditional Choice - Over Age 65 Retirees - Comprehensive Medical - New Plan Only

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

## Comprehensive Medical Plan

### PLAN FEATURES

Calendar Year **Deductible\*** \$250

Family **Deductible\*** \$500

Common Accident **Deductible** \$250

\*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

*Separate Accident Benefit* 100%, deductible waived

**Plan Payment Limit** excludes plan **deductible and precertification** penalties.

**Individual Payment Limit:** 2% of your Base Annual Salary

**Family Payment Limit:** 4% of your Base Annual Salary

### PLAN FEATURES

*Lifetime Maximum Benefit per person* \$1,000,000

*Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, and the remaining Payment Percentage. You are responsible for full payment of any non-covered expenses you incur.*

*All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.*

## PLAN FEATURES

### Preventive Care Benefits

#### **Routine Physical Exams**

Adults and Children.

Includes coverage for immunizations.

100% per exam

No **copay** or Calendar Year **deductible** applies.

#### Maximum Exams per Calendar Year

Age 3 and over

1 exam up to a \$500 per person combined Calendar Year maximum\*

\* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.

Calendar Year maximum does not apply to immunizations.

#### **Preventive Care Immunizations**

Performed in a facility or **physician's** office

100% per visit

No **copay** or **deductible** applies.

#### **Well Child Exams**

Includes coverage for immunizations.

100% per exam

No **copay** or Calendar Year **deductible** applies.

#### Maximum Exams

Under age 3

first 12 months of life

7 exams

13th-24th months of life

3 exams

25th-36th months of life

3 exams

#### **Screening & Counseling Services -**

**Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products**

100% per visit

No **copay** or Calendar Year **deductible** applies.

*Obesity*

Maximum Visits per 12

*(This maximum applies only to Covered Persons ages 22 & older.)*

26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)\**

**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

*Misuse of Alcohol and/or Drugs*

Maximum Visits per 12

5 visits\*

**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

*Use of Tobacco Products*

Maximum Visits per 12

8 visits\*

**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

***Routine Gynecological Exam***

100% per exam

No **copay** or Calendar Year **deductible** applies.

Maximum per Calendar Year

1 exam up to a \$500 per person combined Calendar Year maximum\*

\* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.

**PLAN FEATURES**

***Routine Cancer Screenings***

***Routine Mammography***

For the 1<sup>st</sup> routine or diagnostic Mammogram per Calendar Year

100% per test

No **copay** or Calendar Year **deductible** applies.

Additional Mammograms

80% after Calendar Year **deductible**

<b><i>Prostate Specific Antigen Test</i></b> For covered males.	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum Test per Calendar Year	1 test up to a \$500 per person combined Calendar Year maximum
* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.	
Calendar Year maximum does not apply to immunizations.	
<b><i>Routine Digital Rectal Exam</i></b> For covered males.	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum exam per Calendar Year	1 exam up to a \$500 combined Calendar Year maximum*
* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.	
<b><i>Routine Pap Smears</i></b>	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum Tests per Calendar Year	1 test
<b><i>Fecal Occult Blood Test</i></b>	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum Tests per Calendar Year	1 test



<b><i>Sigmoidoscopy</i></b> Age 50 and over	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum Tests per 5 consecutive year period	1 test
<b><i>Double Contrast Barium Enema (DCBE)</i></b> Age 50 and over	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum Benefit per 5 consecutive year period	1 test
<b><i>Colonoscopy</i></b> age 50 and over	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Benefit Maximum per 10 consecutive year period	1 test
<b><i>Family Planning Services - Female Contraceptives</i></b> <b><i>Female Contraceptive Counseling Services - Office Visits.</i></b>	80% per visit after Calendar Year <b>deductible</b>
<b><i>Family Planning - Female Voluntary Sterilization</i></b> <b><i>Inpatient</i></b>	80% per visit after Calendar Year <b>deductible.</b>
<b><i>Outpatient</i></b>	100% per visit after Calendar Year <b>deductible.</b>
<b><i>Family Planning Services - Female Contraceptives</i></b> <b><i>Female Contraceptives</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.
<b><i>Family Planning Services - Other</i></b> Voluntary Sterilization for Males	
Outpatient	100% per visit after Calendar Year <b>deductible</b>
Voluntary Termination of Pregnancy	
Outpatient	100% per visit after Calendar Year <b>deductible</b>

**PLAN FEATURES**

***Physician Services***

***Physician Office Visits*** 80% per visit after Calendar Year **deductible**  
*(non-surgical)*

***Specialist Office Visits*** 80% per visit after Calendar Year **deductible**

***Physician Office Visit*** 100% per visit after Calendar Year **deductible**  
*(Surgery)*

***Physician Services for Inpatient Facility and Hospital Visits*** 80% per visit after Calendar Year **deductible**

***Administration of Anesthesia***

Inpatient 80% per procedure after Calendar Year **deductible**

Outpatient 100% per procedure after Calendar Year **deductible**

***Prenatal Visits*** Payable in accordance with the type of expense incurred and the place where service is provided.

**PLAN FEATURES**

***Emergency Medical Services***

***Hospital Emergency Facility*** 80% per visit after Calendar Year **deductible**

***Non-Emergency Care in a Hospital Emergency Room*** 80% per visit after Calendar Year **deductible**

**PLAN FEATURES**

***Urgent Medical Services***

***Urgent Medical Care*** 80% per visit after Calendar Year **deductible**  
*(at a non-hospital free standing urgent care facility)*

***Urgent Medical Care*** Refer to *Emergency Medical Services* and *Physician Services*  
*(for other than a non-hospital free standing facility)* above.

**PLAN FEATURES**

***Outpatient Diagnostic and Preoperative Testing***

***Complex Imaging Services***

*Complex Imaging* 100% per procedure after Calendar Year **deductible**

***Diagnostic Laboratory Testing***

*Diagnostic Laboratory Testing* 100% per procedure after Calendar Year **deductible**

***Diagnostic X-Rays (except Complex Imaging Services)***

*Diagnostic X-Rays* 100% per procedure after Calendar Year **deductible**

**PLAN FEATURES**

***Outpatient Surgery***

*Outpatient Surgery* 100% per visit/surgical procedure after Calendar Year **deductible**

**PLAN FEATURES**

***Inpatient Facility Expenses***

*Birthing Center* Payable in accordance with the type of expense incurred and the place where service is provided.

***Hospital Facility Expenses***

Room and Board 80% per admission after Calendar Year **deductible**  
(including maternity)

Other than Room and Board 80% per admission after Calendar Year **deductible**

***Skilled Nursing Inpatient Facility***

100% per admission after Calendar Year **deductible**

**PLAN FEATURES**

***Specialty Benefits***

*Home Health Care (Outpatient)* 100% per visit after the Calendar Year **deductible**

Maximum Visits per  
Calendar Year

50 visits

<b><i>Private Duty Nursing (Outpatient)</i></b>	80% per visit after Calendar Year <b>deductible</b>
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Private Duty Nursing Maximum per Calendar Year	\$15,000
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***Hospice Benefits***

<b><i>Hospice Care – Facility Expenses (Room &amp; Board)</i></b>	100% per admission, no <b>copay</b> or Calendar Year <b>deductible</b> applies, for the 1 <sup>st</sup> \$6,000 of combined expenses per lifetime*
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<b><i>Hospice Care (Other Expenses during a stay)</i></b>	100% per admission no <b>copay</b> or Calendar Year <b>deductible</b> applies, for the 1 <sup>st</sup> \$6,000 of combined expenses per lifetime*
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Maximum Benefit per lifetime	\$6,000 combined maximum*
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\*Combined expenses per lifetime include Inpatient Hospice, Outpatient Hospice and bereavement counseling services. Once this lifetime maximum is met, excess expenses are covered at 50% after **deductible**, per Calendar Year.

<b><i>Hospice Outpatient Visits</i></b>	100% per visit no <b>copay</b> or Calendar Year <b>deductible</b> applies, for the 1 <sup>st</sup> \$6,000 of combined expenses per lifetime*
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Maximum Benefit per lifetime	\$6,000 combined maximum*
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\*Combined expenses per lifetime include Inpatient Hospice, Outpatient Hospice and bereavement counseling services. Once this lifetime maximum is met, excess expenses are covered at 50% after **deductible**, per Calendar Year.

**PLAN FEATURES**

***Infertility Treatment***

<b><i>Basic Infertility Expenses</i></b> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b><i>Comprehensive Infertility Expenses</i></b>	50% per procedure after Calendar Year <b>deductible</b>
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<b><i>Advanced Reproductive Technology (ART) Expenses</i></b>	50% per procedure after Calendar Year <b>deductible</b>
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**PLAN FEATURES**

***Inpatient Treatment of Mental Disorders***

***Mental Disorders***

Room and Board 80% per admission after Calendar Year **deductible**

Other than Room and Board 80% per admission after Calendar Year **deductible**

***Inpatient Residential Treatment Facility*** 80% per admission after Calendar Year **deductible**

***Outpatient Treatment of Mental Disorders***

***Outpatient Services*** 80% per visit after Calendar Year **deductible**

**PLAN FEATURES**

***Inpatient Treatment of Substance Abuse***

***Hospital Facility Expenses***

Room and Board 80% per admission after Calendar Year **deductible**

Other than Room and Board 80% per admission after Calendar Year **deductible**

***Inpatient Residential Treatment Facility*** 80% per admission after Calendar Year **deductible**

***Outpatient Treatment of Substance Abuse***

***Outpatient Services*** 80% per visit after Calendar Year **deductible**

**PLAN FEATURES**

***Obesity Treatment Surgical and Non Surgical***

***Outpatient Obesity Treatment (non surgical)*** 80% per visit after Calendar Year **deductible**

***Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)*** 80% per admission after Calendar Year **deductible**

<i>Outpatient Morbid Obesity Surgery</i>	80% per service after Calendar Year <b>deductible</b>
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited
<b>PLAN FEATURES</b>	
<b>IOE Facility</b>	
<b><i>Transplant Expenses</i></b>	
<i>Transplant Facility Expenses</i>	80% per admission after Calendar Year <b>deductible</b>
<i>Transplant Physician Services</i> (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.
<b>PLAN FEATURES</b>	
<b><i>Other Covered Health Expenses</i></b>	
<i>Acupuncture in lieu of anesthesia</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Ground, Air or Water Ambulance</i>	80% after Calendar Year <b>deductible</b>
<i>Diabetic Education</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum benefit for Diabetic Education per Calendar Year	\$500
<i>Durable Medical and Surgical Equipment</i>	80% per item after Calendar Year <b>deductible</b>
<i>Jaw Joint Disorder Treatment For non-surgical treatment of TMJ and for TMJ intraoral devices</i>	80% per visit after Calendar Year <b>deductible</b>
Maximum Benefit per Lifetime	\$500
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Prosthetic Devices</i>	80% per device after Calendar Year <b>deductible</b>

## PLAN FEATURES

### *Outpatient Therapies*

*Chemotherapy* 100% per visit after Calendar Year **deductible**  
*Includes related services the day of the treatment*

*Infusion Therapy* Payable in accordance with the type of expense incurred and the place where service is provided.

*Radiation Therapy* 100% per visit after Calendar Year **deductible**  
*Includes related services the day of the treatment*

## PLAN FEATURES

### *Short Term Outpatient Rehabilitation Therapies*

*Outpatient Physical and Occupational Therapy* 80% per visit after Calendar Year **deductible**

Combined Physical and Occupational Therapy 90\*  
Maximum visits per Calendar Year

\* Additional visits subject to review for medical necessity. Medically necessary additional visits covered at 50% up to a \$5,000 maximum per Calendar Year.

*Speech Therapy Only* 80% per visit after Calendar Year **deductible**

Speech Therapy Lifetime Maximum \$5,000

## PLAN FEATURES

### *Spinal Manipulation*

*Spinal Manipulation* 50% per visit after Calendar Year **deductible**

Spinal Manipulation Benefit Maximum per Calendar Year \$500

## Expense Provisions

**The following provisions apply to your health expense plan.**

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

## **KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.**

### **Deductible Provisions**

All **covered expenses** accumulate toward the **deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

#### **Calendar Year Deductible**

##### **Individual**

This is an amount of **covered expenses** incurred each Calendar Year for which no benefits will be paid. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

##### **Family Deductible Limit**

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

##### **Common Accident Deductible Limit**

This limit applies when two or more family members are injured in the same accident. The common accident **deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate Calendar Year **deductibles**. When this occurs, and all **covered expenses** related to the accident in that Calendar Year exceed the common accident **deductible** limit, your plan will then pay the excess amount based on the plan **payment** percentage. The added benefit will be reduced by any family **deductible** limit benefit amount paid for the same **covered expenses**. This added benefit does not count toward any Lifetime Maximum Benefit for you and your covered dependents.

##### **Separate Accident Benefit**

An additional benefit is payable for all **covered expenses** incurred on an outpatient basis due to an injury. The injury must be caused by an accident and the treatment must be received no later than 24 hours after the injury.

### **Payment Provisions**

#### **Payment Percentage**

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.



## **Payment Limit**

The **Payment Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Payment Limit**. As to the individual **Payment Limit**, each of you must meet your **Payment Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Payment Limit**. See list below.

### **Individual**

Once the amount of eligible expenses you or your covered dependents have paid during the Calendar Year meets the individual **Payment Limit**, this Plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year for that person.

### **Family Payment Limit**

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **Payment Limit**, these expenses will also count toward a family **Payment Limit**.

To satisfy this family **Payment Limit**, for the rest of the Calendar Year, the following must happen:

The family **Payment Limit** is a cumulative **Payment Limit** for all family members. The family **Payment Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **Payment Limit** amount in a Calendar Year.

### **Expenses That Do Not Apply to Your Payment Limit**

Certain covered expenses do not apply toward your plan payment limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%; and
- Expenses that are not paid, or **precertification** benefit reductions because any required **precertification** for the service(s) or supply was not obtained from **Aetna**.

## **Maximum Benefit Provisions**

### **Lifetime Maximum Benefit**

The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

## **General**

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.

# Schedule of Benefits

**Employer:** The Dow Chemical Company

**ASA:** 783135

**Issue Date:** September 20, 2013

**Effective Date:** January 1, 2014

**Schedule:** 119B

**Booklet Base:** 119

For: Traditional Choice - Over Age 65 Retirees - Comprehensive Medical - Old Plan Only

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

## Comprehensive Medical Plan

### PLAN FEATURES

Calendar Year **Deductible\*** \$250

**Family Deductible\*** \$500

**Common Accident Deductible** \$250

\*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

**Separate Accident Benefit** 100%, deductible waived

### PLAN FEATURES

**Lifetime Maximum Benefit per person** \$50,000\*

\*Lifetime Maximum Benefit excludes expenses reimbursed at 100%

*Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, and the remaining Payment Percentage. You are responsible for full payment of any non-covered expenses you incur.*

*All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.*

## PLAN FEATURES

### Preventive Care Benefits

#### **Routine Physical Exams**

Adults and Children.

Includes coverage for immunizations.

100% per exam

No **copay** or Calendar Year **deductible** applies.

#### Maximum Exams per Calendar Year

Age 3 and over

1 exam up to a \$500 per person combined Calendar Year maximum\*

\* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.

Calendar Year maximum does not apply to immunizations.

#### **Preventive Care Immunizations**

Performed in a facility or **physician's** office

100% per visit

No **copay** or **deductible** applies.

#### **Well Child Exams**

Includes coverage for immunizations.

100% per exam

No **copay** or Calendar Year **deductible** applies.

#### Maximum Exams

Under age 3

first 12 months of life

7 exams

13th-24th months of life

3 exams

25th-36th months of life

3 exams

#### **Screening & Counseling Services -**

**Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products**

100% per visit

No **copay** or Calendar Year **deductible** applies.

*Obesity*

Maximum Visits per 12  
(This maximum applies only to Covered Persons ages 22 & older.)

26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)\*

**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

*Misuse of Alcohol and/or Drugs*

Maximum Visits per 12

5 visits\*

**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

*Use of Tobacco Products*

Maximum Visits per 12

8 visits\*

**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

***Routine Gynecological Exam***

100% per exam

No **copay** or Calendar Year **deductible** applies.

Maximum per Calendar Year

1 exam up to a \$500 per person combined Calendar Year maximum\*

\* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.

**PLAN FEATURES**

***Routine Cancer Screenings***

***Routine Mammography***

For 1<sup>st</sup> routine or diagnostic Mammogram per Calendar Year

100% per test

No **copay** or Calendar Year **deductible** applies.

Additional Mammograms

80% after Calendar Year **deductible**

<b><i>Prostate Specific Antigen Test</i></b> For covered males.	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum Test per Calendar Year	1 test up to a \$500 per person combined Calendar Year maximum
* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.	
Calendar Year maximum does not apply to immunizations.	
<b><i>Routine Digital Rectal Exam</i></b> For covered males.	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum exam per Calendar Year	1 exam up to a \$500 combined Calendar Year maximum*
* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.	
<b><i>Routine Pap Smears</i></b>	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum Tests per Calendar Year	1 test
<b><i>Fecal Occult Blood Test</i></b>	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum Tests per Calendar Year	1 test

<b><i>Sigmoidoscopy</i></b> Age 50 and over	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum Tests per 5 consecutive year period	1 test
<b><i>Double Contrast Barium Enema (DCBE)</i></b> Age 50 and over	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Maximum Benefit per 5 consecutive year period	1 test
<b><i>Colonoscopy</i></b> age 50 and over	100% per test  No <b>copay</b> or Calendar Year <b>deductible</b> applies.
Benefit Maximum per 10 consecutive year period	1 test
<b><i>Family Planning Services - Female Contraceptives</i></b> <b><i>Female Contraceptive Counseling Services - Office Visits.</i></b>	80% per visit after Calendar Year <b>deductible</b>
<b><i>Family Planning - Female Voluntary Sterilization</i></b> <b><i>Inpatient</i></b>	100% per visit after Calendar Year <b>deductible.</b>
<b><i>Outpatient</i></b>	100% per visit after Calendar Year <b>deductible.</b>
<b><i>Family Planning Services - Female Contraceptives</i></b> <b><i>Female Contraceptives</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.
<b><i>Family Planning Services - Other</i></b> Voluntary Sterilization for Males	
Outpatient	100% per visit after Calendar Year <b>deductible</b>
Voluntary Termination of Pregnancy	
Outpatient	100% per visit after Calendar Year <b>deductible</b>

**PLAN FEATURES**

***Physician Services***

***Physician Office Visits and Hospital Outpatient Facility (non-surgical)*** 80% per visit after Calendar Year **deductible**

***Specialist Office Visits*** 80% per visit after Calendar Year **deductible**

***Physician Office Visit and Hospital Outpatient Facility or Ambulatory Surgery Center (Surgery)*** 100% per visit after Calendar Year **deductible**

***Confirmatory Consultation (Second Opinions)*** 100% per visit  
No Calendar Year **deductible** applies.

***Physician Services for Inpatient Facility and Hospital Visits*** 100% per visit after Calendar Year **deductible**

***Administration of Anesthesia*** 100% per procedure after Calendar Year **deductible**

***Prenatal Visits*** Payable in accordance with the type of expense incurred and the place where service is provided.

**PLAN FEATURES**

***Emergency Medical Services***

***Hospital Emergency Facility*** 80% per visit after Calendar Year **deductible**

***Non-Emergency Care in a Hospital Emergency Room*** 80% per visit after Calendar Year **deductible**

**PLAN FEATURES**

***Urgent Medical Services***

***Urgent Medical Care (at a non-hospital free standing urgent care facility)*** 80% per visit after Calendar Year **deductible**

***Urgent Medical Care (for other than a non-hospital free standing facility)*** Refer to *Emergency Medical Services* and *Physician Services* above.



**PLAN FEATURES*****Outpatient Diagnostic and Preoperative Testing******Complex Imaging Services******Complex Imaging*** 100% per procedure after Calendar Year **deductible*****Diagnostic Laboratory Testing******Diagnostic Laboratory Testing*** 100% per procedure after Calendar Year **deductible*****Diagnostic X-Rays (except Complex Imaging Services)******Diagnostic X-Rays*** 100% per procedure after Calendar Year **deductible****PLAN FEATURES*****Outpatient Surgery******Outpatient Surgery******Physician's Office, Hospital Outpatient Facility, or Ambulatory Surgery Center*** 100% per visit/surgical procedure after Calendar Year **deductible*****Associated Physicians*** 100% per visit after Calendar Year **deductible****PLAN FEATURES*****Inpatient Facility Expenses******Birthing Center*** Payable in accordance with the type of expense incurred and the place where service is provided.***Hospital Facility Expenses*** 100% per admission after Calendar Year **deductible**Room and Board  
(including maternity)Other than Room and Board 100% per admission after Calendar Year **deductible*****Skilled Nursing Inpatient Facility*** 100% per admission after Calendar Year **deductible****PLAN FEATURES*****Specialty Benefits******Home Health Care (Outpatient)*** 100% per visit after the Calendar Year **deductible**Maximum Visits per  
Calendar Year 50 visits

***Private Duty Nursing  
(Outpatient)***

80% per visit after Calendar Year **deductible**

***Hospice Benefits***

***Hospice Care – Facility Expenses  
(Room & Board)***

100% per admission, no **copay** or Calendar Year **deductible** applies, for the 1<sup>st</sup> \$6,000 of combined expenses per lifetime\*

***Hospice Care  
(Other Expenses during a stay)***

100% per admission, no **copay** or Calendar Year **deductible** applies, for the 1<sup>st</sup> \$6,000 of combined expenses per lifetime\*

Maximum Benefit per lifetime

\$6,000 combined maximum\*

\*Combined expenses per lifetime include Inpatient Hospice, Outpatient Hospice and bereavement counseling services. Once this lifetime maximum is met, excess expenses are covered at 50%.

***Hospice Outpatient Visits***

100% per visit no **copay** or Calendar Year **deductible** applies, for the 1<sup>st</sup> \$6,000 of combined expenses per lifetime\*

Maximum Benefit per lifetime

\$6,000 combined maximum\*

\*Combined expenses per lifetime include Inpatient Hospice, Outpatient Hospice and bereavement counseling services. Once this lifetime maximum is met, excess expenses are covered at 50%.

**PLAN FEATURES**

***Infertility Treatment***

***Basic Infertility Expenses***

Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.

Payable in accordance with the type of expense incurred and the place where service is provided.

***Comprehensive Infertility Expenses***

50% per procedure after Calendar Year **deductible**

***Advanced Reproductive Technology (ART)  
Expenses***

50% per procedure after Calendar Year **deductible**

**PLAN FEATURES**

***Inpatient Treatment of Mental Disorders***

***Mental Disorders***

Room and Board	100% per admission after Calendar Year <b>deductible</b>
Other than Room and Board	100% per admission after Calendar Year <b>deductible</b>

<b><i>Inpatient Residential Treatment Facility</i></b>	100% per admission after Calendar Year <b>deductible</b>
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***Outpatient Treatment of Mental Disorders***

<b><i>Outpatient Services</i></b>	80% per visit after Calendar Year <b>deductible</b>
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**PLAN FEATURES**

***Inpatient Treatment of Substance Abuse***

***Hospital Facility Expenses***

Room and Board	100% per admission after Calendar Year <b>deductible</b>
Other than Room and Board	100% per admission after Calendar Year <b>deductible</b>

<b><i>Inpatient Residential Treatment Facility</i></b>	100% per admission after Calendar Year <b>deductible</b>
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***Outpatient Treatment of Substance Abuse***

<b><i>Outpatient Services</i></b>	80% per visit after Calendar Year <b>deductible</b>
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**PLAN FEATURES**

***Obesity Treatment Surgical and Non Surgical***

<b><i>Outpatient Obesity Treatment (non surgical)</i></b>	80% per visit after Calendar Year <b>deductible</b>
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<b><i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i></b>	100% per admission after Calendar Year <b>deductible</b>
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<b><i>Outpatient Morbid Obesity Surgery</i></b>	100% per service after Calendar Year <b>deductible</b>
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Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited
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<b>PLAN FEATURES</b>	<b>IOE Facility</b>
<b><i>Transplant Expenses</i></b>	

<b><i>Transplant Facility Expenses Institute of Excellence Facility</i></b>	100% per admission after Calendar Year <b>deductible</b>
<b><i>Transplant Physician Services (including office visits)</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided

<b>PLAN FEATURES</b>	<b>Non-IOE Facility</b>
<b><i>Transplant Expenses</i></b>	

<b><i>Transplant Facility Expenses Non-Institute of Excellence Facility</i></b>	80% per admission after Calendar Year <b>deductible</b>
<b><i>Transplant Physician Services (including office visits)</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided

<b>PLAN FEATURES</b>	
<b><i>Other Covered Health Expenses</i></b>	

<b><i>Acupuncture in lieu of anesthesia</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b><i>Ground, Air or Water Ambulance</i></b>	100% after Calendar Year <b>deductible</b>
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<b><i>Diabetic Education</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum benefit for Diabetic Education per Calendar Year	\$500

<b><i>Durable Medical and Surgical Equipment</i></b>	80% per item after Calendar Year <b>deductible</b>
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<b><i>Jaw Joint Disorder Treatment</i></b> <i>For non-surgical treatment of TMJ and for TMJ intraoral devices</i>	80% per visit after Calendar Year <b>deductible</b>
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Maximum Benefit per Lifetime	\$500
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<b><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b><i>Prosthetic Devices</i></b>	80% per device after Calendar Year <b>deductible</b>
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**PLAN FEATURES**  
***Outpatient Therapies***

<b><i>Chemotherapy</i></b> <i>Includes related services the day of the treatment</i>	100% per visit after Calendar Year <b>deductible</b>
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<b><i>Infusion Therapy</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b><i>Radiation Therapy</i></b> <i>Includes related services the day of the treatment</i>	100% per visit after Calendar Year <b>deductible</b>
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**PLAN FEATURES**  
***Short Term Outpatient Rehabilitation Therapies***

<b><i>Outpatient Physical Therapy</i></b>	100% per visit after Calendar Year <b>deductible</b>
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<b><i>Outpatient Occupational Therapy</i></b>	80% per visit after Calendar Year <b>deductible</b>
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<b><i>Speech Therapy Only</i></b>	80% per visit after Calendar Year <b>deductible</b>
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**PLAN FEATURES**  
***Spinal Manipulation***

<b><i>Spinal Manipulation</i></b>	50% per visit after Calendar Year <b>deductible</b>
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Spinal Manipulation Benefit Maximum per Calendar Year	\$500
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## Expense Provisions

**The following provisions apply to your health expense plan.**

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

**KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.**

## Deductible Provisions

All **covered expenses** accumulate toward the **deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

### Calendar Year **Deductible**

#### **Individual**

This is an amount of **covered expenses** incurred each Calendar Year for which no benefits will be paid. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

#### **Family Deductible Limit**

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

#### **Common Accident Deductible Limit**

This limit applies when two or more family members are injured in the same accident. The common accident **deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate Calendar Year **deductibles**. When this occurs, and all **covered expenses** related to the accident in that Calendar Year exceed the common accident **deductible** limit, your plan will then pay the excess amount based on the plan **payment** percentage. The added benefit will be reduced by any family **deductible** limit benefit amount paid for the same **covered expenses**. This added benefit does not count toward any Lifetime Maximum Benefit for you and your covered dependents.

#### **Separate Accident Benefit**

An additional benefit is payable for all **covered expenses** incurred on an outpatient basis due to an injury. The injury must be caused by an accident and the treatment must be received no later than 24 hours after the injury.

## **Payment Provisions**

### **Payment Percentage**

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

### **Maximum Benefit Provisions**

#### **Lifetime Maximum Benefit**

The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

## **General**

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.

## Preface

The medical benefits plan described in this *Booklet* is a benefit plan of the Employer. These benefits are not insured with **Aetna** but will be paid from the Employer's funds. **Aetna** will provide certain administrative services under the **Aetna** medical benefits plan.

**Aetna** agrees with the Employer to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this *Booklet*. The Employer selects the products and benefit levels under the **Aetna** medical benefits plan.

The *Booklet* describes your rights and obligations, what the **Aetna** medical benefits plan covers, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet*. Your *Booklet* includes the *Schedule of Benefits* and any amendments.

This *Booklet* replaces and supercedes all **Aetna Booklets** describing coverage for the medical benefits plan described in this *Booklet* that you may previously have received.

<b>Employer:</b>	The Dow Chemical Company
<b>Contract Number:</b>	783135
<b>Effective Date:</b>	January 1, 2014
<b>Issue Date:</b>	December 10, 2013
<b>Booklet Number:</b>	119



# Coverage for You and Your Dependents

## Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is “incurred” on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet* for more information about your coverage.

## Treatment Outcomes of Covered Services

**Aetna** is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

# How Your Medical Plan Works

Common Terms

Accessing Providers

It is important that you have the information and useful resources to help you get the most out of your **Aetna** medical plan. This Booklet explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

## Important Notes

- Unless otherwise indicated, “you” refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this Booklet as **covered expenses** that are **medically necessary**.
- This Booklet applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this Booklet in a safe place for future reference.

## Common Terms

Many terms throughout this Booklet are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

## About Your Comprehensive Medical Plan

This **Aetna** medical plan is designed to cover a range of medical services and supplies for the treatment of **illness** and **injury** and other preventive and routine medical expenses. It does not provide benefits for all medical care.

- The plan will pay for **covered expenses** up to the maximum benefits shown in this Booklet.
- Coverage is subject to all the terms, policies and procedures outlined in this Booklet. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers*, *Exclusions*, *Limitations* and *Schedule of Benefits* sections to determine if medical services are covered, excluded, or limited.

## How Your Plan Works

### Accessing Providers and Benefits

- When you need medical care, you can directly access **physicians**, **hospitals** and other health care providers of your choice for covered services and supplies under the plan.

- This plan does not permit assignment of benefits.
- You may have to pay for services at the time that they are rendered. You may be required to pay the full charges and submit a claim form for reimbursement to **Aetna**. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** that you paid directly to a health care provider.
- When you pay a provider directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** from **Aetna**. You must submit a completed claim form and proof of payment to **Aetna**. Refer to the *General Provisions* section of the booklet for a complete description of how to file a claim under this plan.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible, payment percentage** amounts or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

**NOTE:** There are no benefits at all at the facilities listed below, other than outpatient and inpatient emergency services. This means that there is no coverage for both:

- health care services provided by the facility; and
  - health care services provided by physicians and other health care professionals at the facility.
- Houston Physicians Hospital
  - University General Hospital, LP
  - Victory Medical Center LP
  - Oprex Surgery Houston LP
  - Houston MicroSurgery Institute
  - International Center for Surgical Science
  - First Street Hospital
  - Spars Surgical Center
  - Houston Metro Ortho and Spine Surgery Ctr
  - Kirby Surgical Center

For coverage of outpatient and inpatient emergency services by participating and non-participating providers, Health Plan may require a member to submit medical records supporting the emergency medical condition. It is the member's responsibility to submit any requested medical records. One or more providers may submit any requested medical records on the member's behalf, but it remains the member's responsibility to ensure that all requested medical records are submitted. If the member (or providers on the member's behalf) does not submit all requested medical records, all claims for coverage of outpatient and inpatient emergency services will be denied.

## Cost Sharing

### Important Note

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- **Aetna** will reimburse you for a **covered expense** up to the **recognized charge** and the maximum benefits under this Plan, less any cost-sharing required by you such as **deductibles** and **payment percentage**. The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from a health care provider. Your **payment percentage** is based on the **recognized charge**. If your health care provider charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. **Aetna** will only pay up to the **recognized charge**.
- You must satisfy any applicable **deductibles** before the plan begins to pay benefits.

- After you satisfy any applicable **deductible**, you will be responsible for any applicable **payment percentage** for **covered expenses** that you incur. You will be responsible for your **payment percentage** up to any applicable **payment limits** that apply to your plan.
- If you are enrolled in the Traditional Choice “New Plan”, once you satisfy the **payment limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **payment limit**. Refer to your *Schedule of Benefits* for information on what **covered expenses** do not apply to the **payment limit** and for the specific **payment limit** amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* section or the *Schedule of Benefit*.
- You may be billed for any **deductible** or **payment percentage** amounts, or any non-**covered expenses** that you incur.

## Emergency and Urgent Care

You have coverage 24 hours a day, 7 days a week for:

- An **emergency medical condition**; or
- An **urgent condition**.

### In Case of a Medical Emergency

When **emergency care** is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **physician** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **physician** as soon as reasonably possible.

### Coverage for Emergency Medical Conditions

Refer to **Coverage for Emergency Medical Conditions** in the *What the Plan Covers* section.

### In Case of an Urgent Condition

Call your **physician** if you think you need urgent care. **Physicians** usually provide coverage 24 hours a day, including weekends and holidays for urgent care. You may contact any **physician** or **urgent care provider**, for an **urgent care condition** if you cannot reach your **physician**.

If it is not feasible to contact your **physician**, please do so as soon as possible after urgent care is provided. If you need help finding an **urgent care provider** you may call Member Services at the toll-free number on your I.D. card, or you may access Aetna’s online provider directory at [www.aetna.com](http://www.aetna.com).

### Coverage for an Urgent Condition

Refer to **Coverage for Urgent Medical Conditions** in the *What the Plan Covers* section.

### Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition

Follow-up care is not considered an emergency or **urgent condition** and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your **physician** for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for **illness** or **injury**. Refer to your *Schedule of Benefits* for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be provided by a **physician**.

**Important Notice**

Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should **not** be provided by an emergency room facility.

# Requirements For Coverage

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
  - Be included as a covered expense in this Booklet;
  - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
  - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
  - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.
2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.
3. The service or supply must be **medically necessary**. To meet this requirement, the medical services or supply must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms. The provision of the service or supply must be:
  - (a) In accordance with generally accepted standards of medical practice;
  - (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
  - (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
  - (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

For these purposes “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

## Important Note

Not every service or supply that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

# What The Plan Covers

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

## Comprehensive Medical Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

### Preventive Care

This section on Preventive Care describes the **covered expenses** for services and supplies provided when you are well.

#### Routine Physical Exams

**Covered expenses** include charges made by your **physician** for routine physical exams. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.
- Screening for Gestational Diabetes

**Covered expenses** for children from birth to age 18 also include:

- An initial **hospital** check up and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

#### Limitations

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

#### Important Note

Refer to the *Schedule of Benefits* for details about any applicable deductibles, payment percentage, benefit maximums and frequency and age limits for physical exams.

## Routine Cancer Screenings

**Covered expenses** include charges incurred for routine cancer screening as follows:

- Mammograms for covered females
- 1 Pap smear per Calendar Year;
- Gynecological exam;
- 1 fecal occult blood test per Calendar Year; and
- Digital rectal exam and prostate specific antigen (PSA) test for covered males.

The following tests are **covered expenses** if you are age 50 and older when recommended by your **physician**:

- 1 Sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk; *or*
- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer.

## Screening and Counseling Services

**Covered expenses** include charges made by your **physician** in an individual or group setting for the following:

### Obesity

Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- preventive counseling visits and/or risk factor reduction intervention;
- medical nutrition therapy;
- nutrition counseling; and
- healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

### Misuse of Alcohol and/or Drugs

Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

### Use of Tobacco Products

Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco. Coverage includes:

- preventive counseling visits;
- treatment visits; and
- class visits;

to aid in the cessation of the use of tobacco products.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.



#### Limitations:

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

### **Family Planning Services - Female Contraceptives-Voluntary Female Sterilization**

For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the U.S. Food and Drug Administration (FDA).

The following contraceptive methods are **covered expenses** under this Preventive Care benefit:

#### **Voluntary Sterilization**

**Covered expenses** include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

**Covered expenses** under this *Preventive Care* benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

#### **Contraceptives**

**Covered expenses** include charges made by a **physician** for:

- Female contraceptives that are **brand name and generic prescription drugs**;
- Female contraceptive devices including the related services and supplies needed to administer the device.

#### **Limitations:**

Unless specified above, not covered under this Preventive Care benefit are charges for:

- Charges for Oral Contraceptives;
- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services which are for the treatment of an identified **illness** or **injury**;
- Services that are not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care.

### **Family Planning Services - Other**

Covered expenses include charges for certain family planning services, even though not provided to treat an illness or injury.

- Voluntary sterilization for males
- Voluntary termination of pregnancy

Limitations:

Not covered are:

- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your employer; and
- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care.

#### **Important Notes:**

Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Family Planning Services - Other. For more information, see the sections on Family Planning Services - Female Contraceptives, Pregnancy Expenses and Treatment of Infertility in this Booklet.

## **Physician Services**

### **Physician Visits**

Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician's** office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

### **Surgery**

**Covered expenses** include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

### **Anesthetics**

**Covered expenses** include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

## **Hospital Expenses**

Covered medical expenses include services and supplies provided by a **hospital** during your **stay**.

### **Room and Board**

**Covered expenses** include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital's semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.

**Room and board** charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

## Other Hospital Services and Supplies

**Covered expenses** include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**.

**Covered expenses** include hospital charges for other services and supplies provided, such as:

- **Ambulance** services.
- **Physicians** and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

## Outpatient Hospital Expenses

**Covered expenses** include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

### Important Reminders

The plan will only pay for nursing services provided by the **hospital** as part of its charge. The plan does *not* cover private duty nursing services as part of an inpatient **hospital** stay.

If a **hospital** or other health care facility does not itemize specific **room and board** charges and other charges, **Aetna** will assume that 40 percent of the total is for **room and board** charge, and 60 percent is for other charges.

In addition to charges made by the **hospital**, certain **physicians** and other providers may bill you separately during your stay.

Refer to the *Schedule of Benefits* for any applicable **deductible**, **copay** and **payment percentage** and maximum benefit limits.

## Coverage for Emergency Medical Conditions

**Covered expenses** include charges made by a **hospital** or a **physician** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

Please contact your **physician** after receiving treatment for an **emergency medical condition**.

## Coverage for Urgent Conditions

**Covered expenses** include charges made by a **hospital** or **urgent care provider** to evaluate and treat an urgent condition.

Your coverage includes:

- Use of emergency room facilities;
- Use of urgent care facilities;
- **Physicians** services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact your **physician** after receiving treatment of an urgent condition.

## Alternatives to Hospital Stays

### Outpatient Surgery and Physician Surgical Services

**Covered expenses** include charges for services and supplies furnished in connection with outpatient surgery made by:

- A **physician** or **dentist** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a **surgery center** or **hospital** and
- The surgery is not normally performed in a **physician's** or **dentist's** office.

#### Important Note

Benefits for surgery services performed in a **physician's** or **dentist's** office are described under Physician Services benefits in the previous section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the **hospital, surgery center** on the day of the procedure;
- The operating **physician's** services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

### Limitations

Not covered under this plan are charges made for:

- The services of a **physician** or other health care provider who renders technical assistance to the operating **physician**.
- A **stay** in a **hospital**.
- Facility charges for office based surgery.

## Birthing Center

**Covered expenses** include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

## Limitations

Unless specified above, not covered under this benefit are charges:

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Pregnancy Related Expenses* for information about other **covered expenses** related to maternity care.

## Home Health Care

**Covered expenses** include charges made by a **home health care agency** for home health care, and the care:

- Is given under a **home health care plan**;
- Is given to you in your home while you are **homebound**.

Home health care expenses include charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aid services provided in conjunction with and in direct support of care by an **R.N.** or an **L.P.N.**
- Physical, occupational, and speech therapy.
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an **R.N.** or an **L.P.N.**
- Medical supplies, **prescription drugs** and lab services by or for a **home health care agency** to the extent they would have been covered under this plan if you had a **hospital stay**.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit.

In figuring the Calendar Year Maximum Visits, each visit of up to 4 hours is one visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

## Limitations

Unless specified above, *not* covered under this benefit are charges 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 spouse's or your domestic partner's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are **custodial care**.

## Important Reminders

The plan does *not* cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Refer to the *Schedule of Benefits* for details about any applicable home health care visit maximums.

## Private Duty Nursing

**Covered expenses** include private duty nursing provided by a **R.N.** or **L.P.N.** if the person's condition requires **skilled nursing** care and visiting nursing care is not adequate. However, **covered expenses** will not include private duty nursing during a Calendar Year in excess of the Private Duty Nursing Care **Calendar Year** Maximum.

The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in your medication;
- Treatment of an urgent or **emergency medical condition** by a **physician**;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An inpatient **stay**.

## Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a **R.N.** or **L.P.N.** to administer medicines.

## Skilled Nursing Facility

**Covered expenses** include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies, up to the maximums shown in the *Schedule of Benefits*, including:

- **Room and board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

### Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable **skilled nursing facility** maximums.

### Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Charges made for the treatment of:
  - Drug addiction;
  - Alcoholism;
  - Senility;
  - Mental retardation; or
  - Any other mental illness; and
- Daily **room and board** charges over the **semi private rate**.

## Hospice Care

**Covered expenses** include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

### Facility Expenses

The charges made by a **hospital, hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

### Outpatient Hospice Expenses

**Covered expenses** include charges made on an outpatient basis by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a **physician**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a **physician**;

- Medical supplies;
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - **Prescription drugs**;
  - Psychological counseling; Dietary counseling; and
  - Bereavement counseling.

### Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Daily **room and board** charges over the **semi-private room rate**.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.
- Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.

### Important Reminders

Refer to the *Schedule of Benefits* for details about any applicable **hospice care** maximums.

## Other Covered Health Care Expenses

### Acupuncture

The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.

### Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.



## Ambulance Service

Covered expenses include charges made by a professional **ambulance**, as follows:

### Ground Ambulance

Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient **stay** at a **hospital, skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

### Air or Water Ambulance

Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **hospital** to another **hospital**; when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**; **and** the two conditions above are met.

### Limitations

*Not* covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service.

## Diagnostic and Preoperative Testing

### Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a **physician, hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an **illness** or **injury**, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service costing over \$500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

### Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

## Outpatient Diagnostic Lab Work and Radiological Services

**Covered expenses** include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

### Important Reminder

Refer to the *Schedule of Benefits* for details about any **deductible**, **payment percentage** and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

## Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital**, **surgery center**, **physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the tests are:

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**;
- Not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.
- Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

### Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will **not** be covered.

### Important Reminder

Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply. Refer to your *Schedule of Benefits* for information on cost sharing amounts for complex imaging.

## Durable Medical and Surgical Equipment (DME)

**Covered expenses** include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

### **Important Reminder**

Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible, payment percentage** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

## **Experimental or Investigational Treatment**

**Covered expenses** include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided **all** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
- The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
- The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
- The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
- You are treated in accordance with protocol.

## **Pregnancy Related Expenses**

**Covered expenses** include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

**Covered expenses** also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

**Note: Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

## Prosthetic Devices

**Covered expenses** include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness, injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

**Covered expenses** also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- any item listed in the *Exclusions* section.

## Short-Term Rehabilitation Therapy Services

**Covered expenses** include charges for short-term therapy services when prescribed by a **physician** as described below up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital, skilled nursing facility, or hospice facility**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

### **Cardiac and Pulmonary Rehabilitation Benefits.**

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

### **Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.**

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet**.

- Physical therapy (including spinal manipulation) is covered for non-chronic conditions and acute **illnesses and injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function. Coverage for physical therapy is available for the treatment of developmental delays in children to age 18 (as an exception to the above non-chronic condition coverage criteria).
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses and injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function. Coverage for occupational therapy is available for the treatment of developmental delays in children to age 18 (as an exception to the above non-chronic condition coverage criteria).
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from **illness or injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words. Coverage for speech therapy is available for the treatment of developmental delays in children to age 18 (as an exception to the above non-chronic condition coverage criteria).
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Refer to the *Schedule of Benefits* for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

#### **Important Reminder**

Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.

Unless specifically covered above, *not* covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Down's syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services for the treatment of delays in speech development, unless resulting from illness, injury, or congenital defect.
- Services provided during a **stay** in a **hospital, skilled nursing facility, or hospice facility except as stated above;**
- Services not performed by a **physician** or under the direct supervision of a **physician;**
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your domestic partner;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

## Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a **physician, hospital, or surgery center** for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Note: Injuries that occur as a result of a medical (*i.e.*, non surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
  - the defect results in severe facial disfigurement, or
  - the defect results in significant functional impairment and the surgery is needed to improve function

### Reconstructive Breast Surgery

**Covered expenses** include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

#### Important Notice

A benefit maximum may apply to reconstructive or **cosmetic** surgery services. Please refer to the *Schedule of Benefits*.

# Specialized Care

## Chemotherapy

**Covered expenses** include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

## Radiation Therapy Benefits

**Covered expenses** include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

## Outpatient Infusion Therapy Benefits

**Covered expenses** include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

*Not* included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

### Important Reminder

Refer to the *Schedule of Benefits* for details on any applicable **deductible, payment percentage** and maximum benefit limits.

## Diabetic Education

**Covered expenses** include charges for Self-management training provided by a licensed health care provider certified in diabetes self-management training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

## Treatment of Infertility

### Basic Infertility Expenses

**Covered expenses** include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

### Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

To be an eligible covered female for benefits you must be covered under this *Booklet* as an employee, or be a covered dependent who is the employee's spouse.

Even though not incurred for treatment of an **illness** or **injury**, **covered expenses** will include expenses incurred by an eligible covered female for **infertility** if all of the following tests are met:

- A condition that is a demonstrated cause of **infertility** which has been recognized by a gynecologist, or an infertility specialist, and your **physician** who diagnosed you as **infertile**, and it has been documented in your medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than, 19 miU on day 3 of the menstrual cycle.
- The **infertility** is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this *Booklet*.

### Comprehensive Infertility Services Benefits

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an infertility specialist, subject to all the exclusions and limitations of this *Booklet*:

- Ovulation induction with menotropins is subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of this *Booklet*; and
- Intrauterine insemination is subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of this *Booklet*.

### Advanced Reproductive Technology (ART) Benefits

ART is defined as:

- In vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery.

ART services for procedures that are **covered expenses** under this *Booklet*.



## Eligibility for ART Benefits

To be eligible for ART benefits under this *Booklet*, you must meet the requirements above and:

- First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected;
- Be referred by your **physician** to Aetna's infertility case management unit.

## Covered ART Benefits

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the *Exclusions and Limitations* section of the *Booklet*:

- Subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of any combination of the following ART services which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;
- IVF; Intra-cytoplasmic sperm injection ("ICSI"); ovum microsurgery; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit shown on the *Schedule of Benefits* section while covered under an **Aetna** plan;
- Payment for charges associated with the care of the an eligible covered person under this plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under this *Booklet*.

## Exclusions and Limitations

Unless otherwise specified above, the following charges will not be payable as **covered expenses** under this *Booklet*:

- **ART** services for a female attempting to become pregnant who has *not* had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the **infertility** program;
- **ART** services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of sterilization surgery;
- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits;
- Injectable **infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
- **Infertility** Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not **infertile**.

# Jaw Joint Disorder Treatment

The plan covers charges made by a **physician, hospital** or **surgery center** for the diagnosis and treatment of **jaw joint disorder**. A **jaw joint disorder** is defined as a painful condition:

- Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as myofascial pain dysfunction (MPD).

Non-surgical benefits are payable up to the Non-surgical **jaw joint disorder** lifetime maximum shown in the *Schedule of Benefits*.

## Transplant Services

**Covered expenses** include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

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

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

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

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital, outpatient facility** or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

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

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

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

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

### Important Reminders

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

### Limitations

Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

## Obesity Treatment

**Covered expenses** include charges made by a **physician**, licensed or certified dietician, nutritionist or **hospital** for the non-surgical treatment of obesity for the following outpatient weight management services:

- An initial medical history and physical exam;
- Diagnostic tests given or ordered during the first exam; and
- **Prescription drugs.**

## Morbid Obesity Surgical Expenses

Covered medical expenses include charges made by a **hospital** or a **physician** for the surgical treatment of morbid obesity of a covered person.

Coverage includes the following expenses as long as they are incurred within a two-year period:

- One morbid obesity surgical procedure including complications directly related to the surgery;
- Pre-surgical visits;
- Related outpatient services; and
- One follow-up visit.

This two-year period begins with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

Complications, other than those directly related to the surgery, will be covered under the related medical plan's covered medical expenses, subject to plan limitations and maximums.

### Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in the Booklet; and.
- Services which are covered to any extent under any other part of this Plan.

### Important Reminder

Refer to the *Schedule of Benefits* for information about any applicable benefit maximums that apply to **morbid obesity** treatment.

## Treatment of Mental Disorders and Substance Abuse

### Treatment of Mental Disorders

**Covered expenses** include charges made for the treatment of **mental disorders** by **behavioral health providers**.

### Important Note

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Medical Plan Exclusions* for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a **physician** or licensed provider; and
- The Plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

### Inpatient Treatment

**Covered expenses** include charges for **room and board** at the **semi-private room rate**, and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

## Partial Confinement Treatment

**Covered expenses** include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

## Outpatient Treatment

**Covered expenses** include charges for treatment received while not confined as a full-time inpatient in a **hospital, psychiatric hospital or residential treatment facility**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

### Important Reminder

- Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums and **Payment Limit** that may apply to your **mental disorders** benefits.

## Treatment of Substance Abuse

**Covered expenses** include charges made for the treatment of **substance abuse** by **behavioral health providers**.

### Important Note

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Medical Plan Exclusions* for more information.

## Substance Abuse

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a **physician** or licensed provider; and
- The plan is for a condition that can be favorably changed.

Please refer to the *Schedule of Benefits* for any **substance abuse deductibles**, maximums and Payment Limit that may apply to your **substance abuse** benefits.

## Inpatient Treatment

This Plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital or residential treatment facility**, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of **substance abuse**.
- “Medical complications” include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital** is covered only when the **hospital** does not have a separate treatment facility section.

## Outpatient Treatment

**Outpatient treatment** includes charges for treatment received for **substance abuse** while not confined as a full-time inpatient in a **hospital, psychiatric hospital or residential treatment facility**.

This Plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

## Partial Confinement Treatment

**Covered expenses** include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of **substance abuse**.

Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

### Important Reminder

- Please refer to the *Schedule of Benefits* for any **copayments/ deductibles**, maximums and Payment Limit that may apply to your **substance abuse** benefits.

## Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

**Covered expenses** include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out 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. Dental implant surgery, however, may be covered when medically necessary.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

**Hospital** services and supplies received for a **stay** required because of your condition.

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

- (a) Natural teeth damaged, lost, or removed; or
- (b) Other body tissues of the mouth fractured or cut

due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the Calendar Year of the **accident** or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

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

## Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under this Booklet. This also includes **prescription drugs** or supplies if:

- such **prescription drugs** or supplies are unavailable or illegal in the United States; or
- the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

Behavioral Health Services:

- Alcoholism or **substance abuse** rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for **detoxification** or treatment of alcoholism or **substance abuse** is specifically provided in the *What the Medical Plan Covers* Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet.

Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges for a service or supply furnished by a **provider** in excess of the **recognized charge**.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Contraception, except as specifically described in the *What the Plan Covers* Section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically provided in the *What the Plan Covers* section.

Court ordered services, including those required as a condition of parole or release.

### **Custodial Care**

Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of **dentists**, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants except as specifically listed in the *What the Plan Covers* section , false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;



- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drugs**;
- Self-injectable **prescription drugs** and medications;
- Any **prescription drugs**, injectables, or medications or supplies provided by the customer or through a third party vendor contract with the customer; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills regardless of the place of service.

Note: This exclusion does not apply to training directly related to the care of a medical (non-behavioral) condition such as learning to change a dressing or care for a colostomy.

Examinations:

- Any health examinations required:
  - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - by any law of a government;
  - for securing insurance, school admissions or professional or other licenses;
  - to travel;
  - to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

Any special medical reports not directly related to treatment except when provided as part of a covered service.

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

**Experimental or investigational** drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- health resorts;

- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Infertility: except as specifically described in the *What the Plan Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;

- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

### **Maintenance Care.**

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician's** practice;
- Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public **hospital** or other facility is required to provide; or
  - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services, except as specifically described in the *Private Duty Nursing* provision in the *What the Plan Covers* Section.

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;

- Prosthetic devices; and
- Medical or psychological counseling.

Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

Services of a resident **physician** or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet.

Services that are not covered under this Booklet.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Speech therapy for treatment of delays in speech development, except as specifically provided in the *What the Medical Plan Covers Section*. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What the Plan Covers* section.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat **illnesses, injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;

- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Tobacco Use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically provided in the ***What the Plan Covers*** section.

Transplant-The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise **precertified** by **Aetna**.

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in the *What the Plan Covers* section.

Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Aetna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Vision-related services and supplies, except as described in the *What the Plan Covers* section. The plan does not cover:

- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as specifically provided in the *What the Plan Covers* section, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Work related: Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or **injury** under such law, that illness or **injury** will be considered "non-occupational" regardless of cause.

# Coordination of Benefits - What Happens When There is More Than One Health Plan

Other Plans Not Including Medicare

## COB if You Are Less than 65 Years of Age

When your Spouse of Record/Domestic Partner of Record is enrolled for medical coverage through his or her non Dow affiliated employer or former employer and under the Dow Plan, benefit payments will be coordinated with your Dow Plan. This means that claims may be filed to collect from both plans, but total benefits paid by Dow cannot exceed the negotiated fee schedule for services received through a Network provider or **Recognized Charge** for services received through an Out-of-Network or Out-of-Area provider. Note that dual coverage usually does NOT provide 100% coverage.

## Primary versus Secondary Plan

When two different group plans provide coverage for you and your family members, the plan which is primary pays benefits first. The plan that is secondary determines benefits available after payment by the primary plan. The chart below shows how it works. This chart does not apply to Coordination of Benefits with Medicare. See "COB with Medicare" chart.

When the patient is:	Your Dow Plan will be:	The other group plan will be:
The Dow Retiree*: (without new employment)	Primary	Secondary**
The Dow Retiree*: (actively at work elsewhere with benefits)	Secondary	Primary
A non-Dow Spouse of Record / Domestic Partner of Record	Secondary	Primary
A Dependent child, and the parent whose birthday falls earlier in the year is the Dow Retiree*:	Primary	Secondary**
A Dependent child, and the parent whose birthday falls later in the year is the Dow Retiree*:	Secondary	Primary
* or 60 Point or 65 Point Retiree Medical Severance Plan Participant		
** When the other group plan does not include a Coordination of Benefits provision, the other plan is always primary. Court rulings may supersede the order of benefits determination.		
If you are in an automobile accident, your automobile insurance will be the primary plan for your medical expenses resulting from the accident.		

## Dow as the Secondary Plan (not Applicable to COB with Medicare)

The following rules apply when the Dow Plan provides secondary coverage:

- Dow pays based on the balance remaining following payment by the primary plan, using all Dow benefits provisions.
- If payment by the primary plan is equal to or greater than either Dow's **negotiated charge** (if services were received through a Network provider) or the **recognized charge** (if services were received through an Out-of-Network or Out-of-Area provider), no benefits will be payable by the Dow Plans.
- Dow does not reimburse for expenses not covered by the Dow Plans.
- If your Spouse of Record's/Domestic Partner of Record's non Dow employer offers a choice of plans, *the Dow Plan benefits will be coordinated with those of the plan that is most comparable to the Dow Plan, regardless of the non Dow plan in which your Spouse of Record/Domestic Partner of Record is actually enrolled.*
- If your Spouse of Record's/Domestic Partner of Record's plan is a health maintenance organization (HMO) and a service normally provided by the HMO is received from a provider not affiliated with the HMO, no benefits will be payable under the Dow Plan. Each HMO has its own coordination of benefits guidelines. Please refer to the HMO for details. Generally, HMOs will only coordinate benefits with other HMOs if Network providers are used and the other HMO's rules have been followed.
- If your Spouse of Record's/Domestic Partner of Record's plan has special requirements, including but not limited to, mandatory second surgical opinions, use of Network Providers, outpatient surgery for certain procedures, precertification of hospital admissions or pre admission testing, the Dow Plan will not cover any expenses resulting from failure to comply with those requirements.
- Dual coverage usually does not provide 100% coverage.

Periodically, you may be requested to provide coordination of benefits information including, but not limited to, whether your Spouse of Record/Domestic Partner of Record works, details about the coverage available as a result of that employment and specific coverage information. The Plan may withhold Plan benefits if you or your Dependents fail to produce the required information.



# When You Have Medicare Coverage

## Effect of Medicare

### COB with Medicare Parts A & B

When Medicare is involved, Coordination of Benefits is more complex. The Dow Plans coordinate benefits with Medicare Parts A and B. They do NOT coordinate with Medicare Part D. To determine which plan pays first, second and third, refer to the following chart:

	Your Dow Plan will pay:	The other group plan will pay:	Medicare will pay:
If you are the patient and you and your non Dow Spouse of Record/Domestic Partner of Record are both retired and Enrolled in Medicare:	2nd	3rd	1st
If your non Dow Spouse of Record/Domestic Partner of Record is the patient and you and your Spouse of Record/Domestic Partner of Record are both retired and enrolled in Medicare:	3rd	2nd	1st
If you are the patient and you are retired and enrolled in Medicare, and your non Dow Spouse of Record/Domestic Partner of Record is an active employee:	3rd	1st	2nd
If you are retired and your non Dow Spouse of Record/Domestic Partner of Record is the patient and is an active employee enrolled in Medicare:	3rd	1st	2nd

These are the guidelines for Coordination of Benefits when Medicare is involved:

**Note:** If you use a provider who has opted out of, dis-enrolled from, or is non participating with Medicare, we will assume that Medicare benefits exist. Your Dow Plan will reduce the benefits by the amount that would have been paid by Medicare had the provider not opted out of, or dis-enrolled from Medicare.

**If you are age 65 or older enrolled in Medicare Parts A and B,** Medicare is the primary plan. Your Dow Plan is secondary, paying based on the Dow coverage level and the Plan Allowable Amount.

Submit your claims first to Medicare, then send your Medicare worksheet, along with a copy of the bill, to your claims administrator. This will be done electronically for you in many cases. Your Dow Plan will compute the normal benefit and reduce it by the amount paid by Medicare.

**If your Spouse of Record/Domestic Partner of Record is age 65 or older and is a full time employee of another company,** he or she will have primary coverage through the other employer's plan. If you are age 65 or older, Retired, and covered as a Dependent under your Spouse of Record's/Domestic Partner of Record's plan, that plan will be primary. For more information about coverage for employed Spouses of Record/Domestic Partners of Record, contact your medical claims administrator.

**If your Spouse of Record/Domestic Partner of Record is age 65 or older and is a retiree of another company,** he or she should not cancel coverage under the other employer's plan. The Dow Plan will not provide coverage unless your Spouse of Record/Domestic Partner of Record is enrolled in the other employer's plan. In this case Medicare will pay benefits first for your Spouse of Record/Domestic Partner of Record, the other employer's plan will pay second, and the Dow Plan will pay third on his or her eligible expense.

### **COB with Automobile Insurance**

Sometimes a Participant or Dependent is entitled to health care benefits through automobile insurance. Should this type of situation occur, the benefits under your Dow Plans will be coordinated so that the total benefits from all plans do not exceed the **negotiated charge** (for Network services) or the **recognized charge** (for Out-of-Network services). Your Dow Plan will be secondary to the auto insurance carrier.

# General Provisions

## Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

## Physical Examinations

**Aetna** will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

## Legal Action

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

## Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. If you have any questions about the terms of the **Aetna** medical benefits plan or about the proper payment of benefits, contact your employer or **Aetna**.
- The **Aetna** medical benefits plan may be changed or discontinued with respect to your coverage.

## Assignments

Coverage and your rights under this **Aetna** medical benefits plan may not be assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

## Misstatements

**Aetna's** failure to implement or insist upon compliance with any provision of this **Aetna** medical benefits plan at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this **Aetna** medical benefits plan.

## Reporting of Claims

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

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

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed later than the end of the Calendar Year following the year the eligible expenses were incurred.

## Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

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

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

## 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.

## Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna's** Home Office at:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

You may also use **Aetna's** toll free Member Services phone number on your ID card or visit **Aetna's** web site at [www.aetna.com](http://www.aetna.com).

## Effect of Benefits Under Other Plans

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

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care, if any,) on the date of your coverage under such HMO Plan.

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

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

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

## Discount Programs

### Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

## Incentives

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

## Appeals Procedure

### Definitions

**Adverse Benefit Determination:** A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

**Appeal:** A written request to Aetna to reconsider an **adverse benefit determination**.

**Complaint:** Any written expression of dissatisfaction about quality of care or the operation of the Plan.

**Concurrent Care Claim Extension:** A request to extend a previously approved course of treatment.

**Concurrent Care Claim Reduction or Termination:** A decision to reduce or terminate a previously approved course of treatment.

**Pre-Service Claim:** Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

**Post-Service Claim:** Any claim that is not a “Pre-Service Claim.”

**Urgent Care Claim:** Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

## Claim Determinations

### Urgent Care Claims

Aetna will make notification of an **urgent care claim** determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

### Pre-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar days claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15 calendar days period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

### Post-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

## Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, Aetna will make notification of a claim determination for **emergency or urgent care** as soon as possible but not later than 24 hours, with respect to **emergency or urgent care** provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

## Concurrent Care Claim Reduction or Termination

Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

## Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

## Appeals of Adverse Benefit Determinations

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your level one **appeal**. Your **appeal** may be submitted verbally or in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

The notice of an **adverse benefit determination** will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna's Customer Service Unit at the toll-free phone number on your ID card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing verbal or written consent to Aetna.

## Level One Appeal - Group Health Claims

A level one **appeal** of an **adverse benefit determination** shall be provided by Aetna personnel not involved in making the **adverse benefit determination**.

## Urgent Care Claims (May Include concurrent care claim reduction or termination)

Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

## Pre-Service Claims (May Include concurrent care claim reduction or termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

## Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

### **Level Two Appeal**

If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, you or your authorized representative have the right to file a level two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of notice of a level one **appeal**.

A level two **appeal** of an **adverse benefit determination** of an **urgent care claim, a Pre-Service Claim, or a Post-Service Claim** shall be provided by Aetna personnel not involved in making an **adverse benefit determination**.

#### **Urgent Care Claims (May Include concurrent care claim reduction or termination)**

Aetna shall issue a decision within 36 hours of receipt of the request for a level two **appeal**.

#### **Pre-Service Claims (May Include concurrent care claim reduction or termination)**

Aetna shall issue a decision within 15 calendar days of receipt of the request for level two **appeal**.

#### **Post-Service Claims**

Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two **appeal**.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

### **Exhaustion of Process**

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:

- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

### **Health Claims – Voluntary Appeals**

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

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

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

### **External Review**

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is **experimental or investigational** in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna's decision. An external review is a review by an independent **physician**, selected by an External Review Organization, who has expertise in the problem or question involved.



To request an external review, the following requirements must be met:

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

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

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

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

Aetna, the Company and the Health Plan will abide by the decision of the External Review Organization, except where Aetna can show conflict of interest, bias or fraud.

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

For more information about Aetna's External Review process, call the toll-free Customer Services telephone number shown on your ID card.

# Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet.

## A

### Accident

This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Contract. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

### Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

### Ambulance

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

### Average Wholesale Price (AWP)

The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

## B

### Behavioral Health Provider/Practitioner

A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

### Birthing Center

A freestanding facility that meets **all** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.

- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

## Body Mass Index

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

## Brand-Name Prescription Drug

A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

## C

### Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

### Cosmetic

Services or supplies that alter, improve or enhance appearance.

### Covered Expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

### Creditable Coverage

A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-CHIP).

### Custodial Care

Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);

- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

## D

### Day Care Treatment

A **partial confinement treatment** program to provide treatment for you during the day. The **hospital, psychiatric hospital or residential treatment facility** does not make a room charge for **day care treatment**. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

### Deductible

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

### Dentist

A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

### Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

### Directory

A listing of all **network providers** serving the class of employees to which you belong. The contractholder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna's** online provider **directory**, DocFind®.

### Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **illness or injury**;
- Suited for use in the home;

- Not normally of use to people who do not have an **illness** or **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

**Durable medical and surgical equipment** does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

## E

### Emergency Care

This means the treatment given in a **hospital's** emergency room to evaluate and treat an **emergency medical condition**.

### Emergency Medical Condition

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

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

### Experimental or Investigational

Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; 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.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

that states that it is **experimental or investigational**, or for research purposes.

## G

### Generic Prescription Drug

A **prescription drug**, that is identified by its:

- chemical;
- proprietary; or
- non-proprietary name; and
- is accepted by the U.S. Food and Drug Administration as therapeutically the same; and
- can be replaced with drugs with the same amount of active ingredient; and
- so stated by Medispan or any other publication named by **Aetna** or consort.

## H

### Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

### Home Health Care Agency

An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

## Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

## 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

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- 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.
- Uses 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; and
- 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

A facility, or distinct part of one, that meets all of the following requirements:

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

## Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

*In no event* does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

## Hospitalization

A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

## I

### Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

### Infertile or Infertility

The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- *For a woman who is under 35 years of age:* 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- *For a woman who is 35 years of age or older:* 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.



## **Injury**

An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

## **J**

### **Jaw Joint Disorder**

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofascial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

## **L**

### **Late Enrollee**

This is an employee in an Eligible Class who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the employee did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time.

However, an eligible employee or dependent may not be considered a **Late Enrollee** under certain circumstances. See the *Special Enrollment Periods* section of the Booklet.

### **Lifetime Maximum**

This is the most the plan will pay for **covered expenses** incurred by any one covered person in their lifetime.

### **L.P.N.**

A licensed practical or vocational nurse.

## **M**

### **Mail Order Pharmacy**

An establishment where **prescription drugs** are legally given out by mail or other carrier.

### **Maintenance Care**

Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

## Medically Necessary or Medical Necessity

These are health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must be:

- a) In accordance with generally accepted standards of medical or dental practice;
- b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
- c) Not mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
- d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

## Mental Disorder

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

Any one of the following conditions is a **mental disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.

Also included is any other mental condition which requires **Medically Necessary** treatment.

## Morbid Obesity

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

## N

### **Network Advanced Reproductive Technology (ART) Specialist**

A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology (ART)** services.

### **Night Care Treatment**

A **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital, psychiatric hospital or residential treatment facility**. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

### **Non-Occupational Illness**

A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** 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 **illness** 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-Specialist**

A **physician** who is not a **specialist**.

### **Non-Urgent Admission**

An inpatient admission that is not an **emergency admission** or an **urgent admission**.

## O

### **Occupational Injury or Occupational Illness**

An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

## Occurrence

This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

## Orthodontic Treatment

This is any:

- Medical service or supply; or
- Dental service or supply;

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

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

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

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

## P

### Partial Confinement Treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat substance abuse or **mental disorders**. The plan must meet these tests:

- It is carried out in a **hospital; psychiatric hospital or residential treatment facility**; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.
- **Day care treatment** and **night care treatment** are considered **partial confinement treatment**.

### Payment Percentage

**Payment percentage** is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “plan **payment percentage**,” and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **payment percentage** amounts.

### Payment Limit

With respect to the Traditional Choice “New Plan” only, **Payment limit** is the maximum out-of-pocket amount you are responsible to pay for your **payment percentage** for **covered expenses** during your calendar year. Once you satisfy the **payment limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the calendar year.

## Pharmacy

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

## Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

## Precertification or Precertify

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

## Prescriber

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

## Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- 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 injectable insulin.

## Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmity-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 **psychiatric physician** 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 services** 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.

## Psychiatric Physician

This is a **physician** who:

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

## R

### Recognized Charge

The **covered expense** is only that part of a charge which is the **recognized charge**.

As to medical, vision and hearing expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  - the 90th percentile of the Prevailing Charge Rate; for the Geographic Area where the service is furnished.

As to **prescription drug** expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- 110% of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current average wholesale price of a **prescription drug** listed in the Medi-Span weekly price updates (or any other similar publication chosen by **Aetna**).

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

**Aetna** may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;

- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

**Aetna** Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and dentists practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- **Geographic Area:** This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- **Prevailing Charge Rates:** These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.

#### **Important Note**

**Aetna** periodically updates its systems with changes made to the Prevailing Charge Rates.

*What this means to you* is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

#### **Additional Information**

**Aetna's** website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

### **Rehabilitation Facility**

A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

### **Rehabilitative Services**

The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

### **Residential Treatment Facility (Mental Disorders)**

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).

- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

## **Residential Treatment Facility (Substance Abuse)**

This is an institution that meets all of the following requirements:

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

## **R.N.**

A registered nurse.

## **Room and Board**

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



## S

### Semi-Private Room Rate

The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

### Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an **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 an **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**.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of **Hospitals** of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

**Skilled nursing facilities** also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

**Skilled nursing facility** does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.

### Skilled Nursing Services

Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

## Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

## Specialty Care

Health care services or supplies that require the services of a **specialist**.

## Stay

A full-time inpatient confinement for which a **room and board** charge is made.

## Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

## Surgery Center

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**; and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

# T

## Terminally Ill (Hospice Care)

**Terminally ill** means a medical prognosis of 6 months or less to live.

# U

## Urgent Admission

A **hospital** admission by a **physician** due to:

- The onset of or change in an **illness**; or
- The diagnosis of an **illness**; or
- An **injury**.
- The condition, 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.

## Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - 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 **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician's** office, but only one that has contracted with **Aetna** to provide urgent care.

It is not the emergency room or outpatient department of a **hospital**.

## Urgent Condition

This means a sudden **illness; injury; or condition**; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

### **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 you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

### **Notice Regarding Women's Health and Cancer Rights Act**

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- (1) all stages of 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 provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

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

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/home/regsguidance.asp>, and this U.S. Department of Labor website, [http://www.dol.gov/ebsa/consumer\\_info\\_health.html](http://www.dol.gov/ebsa/consumer_info_health.html).