CARILION CLINIC MEDICAL PLAN

Summary Plan Description

Effective: January 1, 2016

Contents

Welcome

This book can help you learn about the Carilion Clinic Medical Plan (referred to as the Plan) offered by Carilion Clinic.

The Plan is administered by Aetna Life Insurance Company.

About This Book

The Employee Retirement Income Security Act of 1974, as amended (known as ERISA) requires Carilion Clinic to issue a Summary Plan Description (SPD) describing the benefits provided to eligible employees. This book is the SPD for the Plan. In it, you'll find:

- Who is eligible for coverage;
- How to enroll and when you are allowed make changes to your coverage;
- What the Plan covers and does not cover;
- Tools and resources to help you use your medical plan;
- When coverage starts and ends;
- How to file a claim or appeal a claim decision;
- Definitions of key terms

Refer to this SPD when you need to understand how your medical benefits work. We have tried to explain the Plan rules in simple terms. However, medical terms are usually complicated. If you have questions or need help:

- Refer to Benefit Resources and Tools; or
- Call Aetna Member Services at the number shown on your ID card.

Understanding the Terms

Words and phrases that appear in **bold type** are defined in the Glossary.

Your Medical Plan at a Glance

Summary of Benefits

This chart outlines the benefits available to you under the Carilion Clinic Medical Plan.

This chart summarizes the benefits available to you under the Carilion Clinic Medical Plan.

Plan Feature	**Level A*** **Carilion Network**	**Level B*** **Aetna Network**	**Level C** **Out-of-Network**
Annual Deductible			
Individual	$100	$500	$1,000
Family	$200	$1,000	$2,000
Out-of-Pocket Maximum (includes deductible and copays)			
Individual	$3,000	$3,000	$7,500
Family	$6,000	$6,000	$15,000

*The deductible is waived for certain in-network physician expenses. See the following chart for more detailed information.

Covered Services	**Level A** **Carilion Network**	**Level B** **Aetna Network**	**Level C** **Out-of-Network**
Preventive Care[*1]			
Routine Physical Exam • 1 exam per calendar year	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay
Well Child Visits • 1st 12 months: 7 exams • 13-24 months: 3 exams • 25-36 months: 3 exams • age 3-18 years: 1 exam per calendar year	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay

Covered Services	Level A Carilion Network	Level B Aetna Network	Level C Out-of-Network
Screening and Counseling			
• obesity – up to age 22: unlimited visits – age 22 and over: up to 26 visits per calendar year (healthy diet counseling limited to 10 visits)	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay
• use of tobacco products: up to 8 counseling sessions per calendar year	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay
• misuse of alcohol or drugs: up to 5 visits per calendar year	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay
• women's health screenings and counseling	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay
Routine Prostate Screening • 1 PSA and DRE per calendar year for men age 40 and over	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay
Routine Colorectal Cancer Screening *(for those age 50 and over who are at average risk)* • sigmoidoscopy: 1 every 5 years • colonoscopy: 1 every 10 years	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay
Routine Annual Ob/Gyn Exam *(for those age 21 and over. Includes one Pap smear and related lab fees)* • 1 exam per calendar year	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay

Covered Services	Level A Carilion Network	Level B Aetna Network	Level C Out-of-Network
Routine Mammogram • age 35-39: 1 baseline mammogram • age 40 and over: 1 mammogram per calendar year	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay
Vision and Hearing			
Routine Vision Exams • 1 exam per calendar year	You pay $15 copay; then Plan pays 100%	You pay $15 copay; then Plan pays 100%	You pay 50% after the deductible; Plan pays 50%
Routine Hearing Exams	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay
Outpatient Care			
Physician's Office *(internal medicine, pediatrics, family practice, general medicine)*	You pay $20 copay; then Plan pays 100%	You pay $20 copay; then Plan pays 100%	You pay 50% after the deductible; Plan pays 50%
Specialist Office	You pay $40 copay; then Plan pays 100%	You pay $40 copay; then Plan pays 100%	You pay 50% after the deductible; Plan pays 50%
EVisit	You pay $20 (PCP) or $40 (Specialist) copay; Plan pays 100%	You Pay $20 (PCP) or $40 (Specialist) copay; Plan pays 100%	Not covered
Acupuncture	You pay $40 copay; then Plan pays 100%	You pay $40 copay; then Plan pays 100%	You pay 50% after the deductible; Plan pays 50%
Walk-In Clinic	You pay $20 copay; then Plan pays 100%	You pay $20 copay; then Plan pays 100%	Not covered
Allergy Testing	You pay $20 (PCP) or $40 (Specialist) copay; Plan pays 100%	You pay $20(PCP) or $40 (Specialist) copay; Plan pays 100%	You pay 50% after the deductible; Plan pays 50%

Covered Services	Level A Carilion Network	Level B Aetna Network	Level C Out-of-Network
Allergy Injections	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	You pay 50% after the deductible; Plan pays 50%
Family Planning and Maternity			
Voluntary Sterilization (men)			
• physician's office	You $40 copay; then Plan pays 100%	You $40 copay; then Plan pays 100%	You pay 50% after the deductible; Plan pays 50%
Voluntary Sterilization (women)	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	You pay 50% after the deductible; Plan pays 50%
Contraceptive Counseling			
• first 2 visits in a 12-month period	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay
• additional visits	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	You pay 50% after the deductible; Plan pays 50%
Contraceptive devices and injectables provided and billed by your physician *(includes insertion/ administration)*			
• generic devices/injectables and devices with no generic equivalent	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay
• brand-name	You pay $20 (PCP) or $40 (Specialist) copay; Plan pays 100%	You pay $20 (PCP) or $40 (Specialist) copay; Plan pays 100%	You pay 50% after the deductible; Plan pays 50%

Covered Services	Level A Carilion Network	Level B Aetna Network	Level C Out-of-Network
Infertility Services *(diagnosis and treatment of the underlying cause of infertility)*	You pay $40 copay; then the Plan pays 100%	You pay $40 copay; then the Plan pays 100%	You pay 50% after the deductible; Plan pays 50%
Routine Maternity Care[*1] *(physician's services)*			
• initial visit to confirm pregnancy	You pay $40 copay; then the Plan pays 100%	You pay $40 copay; then the Plan pays 100%	You pay 50% after the deductible; Plan pays 50%
• routine prenatal office visits	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	You pay 50% after the deductible; Plan pays 50%
• delivery and postnatal care	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	You pay 50% after the deductible; Plan pays 50%
Breast Feeding Support and Supplies			
• lactation counseling			
- visits 1-6 in a 12-month period	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	You pay 50% after the deductible; Plan pays 50%
- additional visits	You pay $20 physician copay or $40 specialist copay; Plan pays 100%	You pay 10% no deductible ***and*** physician or specialist copay; Plan pays 90%	You pay 50% after the deductible; Plan pays 50%
• breast pumps and supplies - 1 manual or electric breast pump per 36-month period	The Plan pays 100% No deductible, no copay	The Plan pays 100% No deductible, no copay	You pay 50% after the deductible; Plan pays 50%

Covered Services	Level A Carilion Network	Level B Aetna Network	Level C Out-of-Network
Hospital Care			
Inpatient Per Confinement Copay	$750	$750	Not applicable
Inpatient Care *(room and board covered up to the hospital's semi-private room rate)*	You pay 10% after deductible ***and*** $750 copay; Plan pays 90%	You pay 30% after deductible ***and*** $750 copay; Plan pays 70%	You pay 50% after the deductible; Plan pays 50%
Surgery and Anesthesia			
Inpatient Surgery	You pay 10% after deductible ***and*** $750 copay; Plan pays 90%	You pay 30% after deductible ***and*** $750 copay; Plan pays 70%	You pay 50% after the deductible; Plan pays 50%
Outpatient Surgery			
• office visit	You pay $40 copay; then the Plan pays 90%	You pay $40 copay; then the Plan pays 90%	You pay 50% after the deductible; Plan pays 50%
• outpatient facility	You pay 10% after deductible ***and*** $400 copay; then the Plan pays 90%	You pay 30% after deductible ***and*** $400 copay; then the Plan pays 70%	You pay 50% after the deductible; Plan pays 50%
Alternatives to Inpatient Hospital Care			
Skilled Nursing Facility Care • up to a maximum of 120 days per calendar year	You pay 10%, no deductible or copay, Plan pays 90%	You pay 10%, no deductible or copay, Plan pays 90%	You pay 50% after the deductible; Plan pays 50%
Home Health Care • up to 90 visits per calendar year	You pay 10%, no deductible or copay, Plan pays 90%	You pay 10%, no deductible or copay, Plan pays 90%	You pay 50% after the deductible; Plan pays 50%

Covered Services	Level A Carilion Network	Level B Aetna Network	Level C Out-of-Network
Private Duty Nursing • $500 maximum per calendar year	You pay 10%, no deductible or copay, Plan pays 90%	You pay 10%, no deductible or copay, Plan pays 90%	You pay 50% after the deductible; Plan pays 50%
Hospice Care	You pay 10%, no deductible or copay, Plan pays 90%	You pay 10%, no deductible or copay, Plan pays 90%	You pay 50% after the deductible; Plan pays 50%
Emergency Care			
Emergency Room	You pay 10% no deductible ***and*** $150 copay; Plan pays 90% Copay waived if admitted	You pay 10% no deductible ***and*** $150 copay; Plan pays 90% Copay waived if admitted	You pay 10% no deductible ***and*** $150 copay; Plan pays 90% Copay waived if admitted
Urgent Care	You pay 10% no deductible ***and*** $20 copay; Plan pays 90%	You pay 30% no deductible ***and*** $50 copay; Plan pays 70%	You pay 50% after the deductible; Plan pays 50%
Ambulance	You pay 10%, no deductible or copay, Plan pays 90%	You pay 10%, no deductible or copay, Plan pays 90%	You pay 50% after the deductible; Plan pays 50%
Other Covered Expenses			
Complex Imaging *(includes MRI, PET scan, and CT scan)*	You pay 10% after deductible ***and*** $150 copay; Plan pays 90%	You pay 10% after deductible ***and*** $150 copay; Plan pays 90%	You pay 50% after the deductible; Plan pays 50%
Diagnostic X-Ray and Lab Tests	You pay 10%, no deductible, Plan pays 90%	You pay 10%, no deductible, Plan pays 90%	You pay 50% after the deductible; Plan pays 50%
Durable Medical Equipment	You pay 10%, no deductible, Plan pays 90%	You pay 10%, no deductible, Plan pays 90%	You pay 50% after the deductible; Plan pays 50%

Covered Services	Level A Carilion Network	Level B Aetna Network	Level C Out-of-Network
Diabetic Equipment and Supplies	You pay 10%, no deductible, Plan pays 90%	You pay 10%, no deductible, Plan pays 90%	You pay 50% after the deductible; Plan pays 50%
Covered Services	**Level A** **Carilion Network**	**Level B** **Aetna Network**	**Level C** **Out-of-Network**
Short-Term Rehabilitation *(physical, occupational, speech)* Up to 30 visits per calendar year for inpatient and outpatient physical and occupational therapy. Up to 30 visits per calendar year for inpatient and outpatient speech therapy.	You pay $25 copay after deductible; then the Plan pays 100%	You pay 30% after the deductible; then the Plan pays 70%	You pay 50% after the deductible; Plan pays 50%
Spinal Manipulation Treatment • up to 30 visits per calendar year	You pay $25 copay; then the Plan pays 100%	You pay $25 copay; then the Plan pays 100%	You pay 50% after the deductible; Plan pays 50%
Behavioral Health Care			
Mental Health Treatment			
• inpatient	You pay 10%, after deductible ***and*** $750 per confinement copay, Plan pays 90%	You pay 30%, after deductible ***and*** $750 per confinement copay, Plan pays 70%	You pay 50% after the deductible; Plan pays 50%
• outpatient	You pay $20 copay; then the Plan pays 100%	You $20 copay; then the Plan pays 100%	You pay 50% after the deductible; Plan pays 50%
Substance Abuse Treatment			

Covered Services	Level A Carilion Network	Level B Aetna Network	Level C Out-of-Network
• inpatient	You pay 10%, after deductible ***and*** $750 per confinement copay, Plan pays 90%	You pay 30%, after deductible ***and*** $750 per confinement copay, Plan pays 70%	You pay 50% after the deductible; Plan pays 50%
• outpatient	You $20 copay; then the Plan pays 100%	You pay $20 copay; then the Plan pays 100%	You pay 50% after the deductible; Plan pays 50%

Prescription Drugs			
Plan Feature			
Out-of-Pocket Maximum			
Individual	$3,350		
Family	$6,700		
Prescription Drugs	**Carilion Pharmacy**	**In-Network Pharmacy**	**Other Pharmacy**
Retail Pharmacy *(up to a 30-day supply)*[*3]			
Generic Contraceptives	The Plan pays 100%	The Plan pays 100%	The Plan pays 100%
Other Generic Drugs	You pay $8 copay	You pay $10 copay	You pay $10 copay
Brand-Name Formulary Drug	You pay $24 copay	You pay $30 copay	You pay $30 copay
Brand-Name Non-Formulary Drug	You pay 20%: $40 minimum/$80 maximum-whichever is greater	You pay 20%: $50 minimum/$100 maximum-whichever is greater	You pay 20%: $50 minimum/$100 maximum-whichever is greater
Diabetic Equipment/Supplies	You pay $10 copay	You pay $10 copay	You pay $10 copay
Note: If a generic substitution is not allowed by the prescriber or you request the brand-name drug when a generic is available, you pay the brand coinsurance plus the cost difference between the brand-name & generic drug.			

Prescription Drugs	
Plan Feature	
Carilion Pharmacy Mail Order *(up to a 90-day supply)*	
Generic Drugs	You pay $16 copay
Brand-Name Formulary Drug	You pay $48 copay
Brand-Name Non-Formulary Drug	You pay the greater of $80 copay or $20% up to a $160 maximum

Preventive Drugs

The Plan covers 100% of the cost of the following, with no copay or deductible, when purchased at an in-network pharmacy:

- Aspirin to prevent heart disease for those ages 45 or older.
- Oral fluoride for children age 6 months through age 5.
- Vitamin D for those ages 65 and older.
- Folic acid supplements for women.

A prescription is required.

[*1] The medical plan's coverage of preventive care follows guidelines that are subject to periodic evaluation and change. You can learn more about preventive care coverage on Aetna's website at **www.aetna.com** or by calling Aetna Member Services at the number on your ID card

[*2] The benefits shown here are for routine maternity care and services provided by your Ob/Gyn, including routine prenatal care, delivery services and postnatal care. Additional services such as laboratory tests and care that is required due to complications of pregnancy are not considered routine. Call Member Services at the number shown on your ID card if you have questions about coverage for care during your pregnancy.

[*3] Up to a 90-supply can be obtained at a Carilion Pharmacy for 2 times the copay for a 30-day supply.

Eligibility and Enrollment

This section describes who is eligible for coverage, when to enroll and when coverage goes into effect.

You are eligible as an Active Employee if you are:

- Employed by Carilion as a full-time employee; or
- A regular part-time Carilion employee who is scheduled to work at least 24 hours per week.

Temporary, leased and contract employees are not eligible to be covered under the Plan.

Your eligible dependents are:

- Your spouse.
- Your children through age 26. "Children" are defined as:
  - Children placed with you for adoption;
  - The children of your domestic partner
  - Stepchildren living with you;
  - Foster children;
  - Children you support under a qualified medical child support order (QMCSO); and
  - Any other child with whom you have a parent-child relationship.
- Your child of any age who is permanently and totally handicapped, provided that the handicap began before the child reached the Plan's age limit for coverage.
- Your same-sex or opposite-sex domestic partner if:
  - You are both at least 18 years old and mentally competent to enter into a contract;
  - You are not related by blood to a degree that would bar marriage in the state where you live;
  - Neither of you is legally married to another person or the domestic partner of anyone else;
  - Sharing the same residence;
  - Financially interdependent; and
  - You and your domestic partner have been in a single, dedicated relationship for at least twelve months and intend to do so indefinitely.

What If My Spouse or Partner and I Both Work for Carilion Clinic?

No one can be covered both as an employee and as a dependent. No dependent may be covered by more than one employee.

If you and your spouse are both eligible employees, you have these options:

- One of you may enroll as an employee and cover the other as a dependent.
- You may each enroll as an employee.

Only one of you may enroll your children as a dependent.

If Your Child Is Adopted

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

If you do not enroll the child within 31 days of placement, you must wait until the next open enrollment period to add the child.

* "Placed with you for adoption" means that you have taken on the legal obligation for total or partial support of the child you plan to adopt.

Qualified Medical Child Support Orders

A qualified medical child support order (QMCSO) is a court order that requires a parent to provide health care benefits to one or more children. A child covered by a QMCSO can be added to the Plan if:

- Coverage under the QMCSO is not effective until after the date your coverage becomes effective; and
- Your child meets the definition of an eligible dependent under the Plan; and
- The Company determines that the order is "qualified."

How to Enroll

What You Need to Do

You must enroll in order to be covered under the Plan. Participation is not automatic. You can enroll:

- Within 31 days of the date you become eligible for coverage;
- During the annual open enrollment period; or
- Within 31 days of a qualified life event.

Annual Open Enrollment

During annual open enrollment, you have a chance to review your coverage needs for the upcoming year and change your coverage choices. You may select a different plan option, if available, or decline medical coverage. The choices you make during open enrollment will be in effect for the following calendar year.

Your current plan choice will be continued automatically for the upcoming plan year unless you request a change during the open enrollment period.

Qualified Life Event Changes

During the calendar year, you may change your coverage elections *only* when you have a "qualified life event." Qualified life events are outlined in the chart below.

What You Need to Do

You must request a change in coverage within 31 days of the qualified life event. If you miss this 31-day deadline, you must wait until the next annual open enrollment period to make a change.

Contact the Carilion Human Resources Department or refer to the My Total Access hub from the Carilion Clinic Intranet to report coverage changes you would like to make due to a qualified life event.

Qualified Life Event	Mid-Year Changes Allowed
You get married	Enroll yourself, your spouse and spouse's dependent children; or Drop coverage for yourself
You enter into a domestic partnership	Enroll yourself, your domestic partner and the children of your domestic partner Drop coverage for yourself
You have a child, by birth or adoption, or add a stepchild or foster child to your family	Enroll yourself, your spouse's or domestic partner's child(ren)
You get divorced, your marriage is annulled or your domestic partnership ends	Drop coverage for your former spouse/domestic partner and child(ren) of spouse/domestic partner
Your covered dependent dies	Drop coverage for the deceased dependent
Your covered child reaches the Plan's maximum age for dependent coverage	Drop coverage for your child

Qualified Life Event	Mid-Year Changes Allowed
Your spouse's or domestic partner's employment changes and, as a result, health care coverage is available under your spouse's or domestic partner's plan	Drop coverage for yourself and any dependents who enroll in your spouse's plan
Your spouse's or domestic partner's employment changes and, as a result, health care coverage under your spouse's or domestic partner's plan is lost or the cost of coverage will increase significantly	Add coverage for yourself and any eligible dependents who lost the other coverage
You gain or lose coverage due to a change in employment status	Add or drop coverage for yourself and any eligible dependents
You move into or out of the service area of the Carilion Clinic Medical Plan network	None
You become eligible for Medicare or Medicaid	Drop coverage for yourself

Medicaid and CHIP Special Enrollment/Special Enrollees

You may also enroll outside of the annual open enrollment period if:

- You or your dependent no longer qualifies for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- You or your dependent becomes eligible for premium assistance for Plan coverage through Medicaid or CHIP.

You must request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

When Coverage Begins

When Plan coverage begins depends on when you and your dependents enroll:

- For people who enroll when they first become eligible, coverage begins the first day of the month after being employed for 30 days.
- For people enrolling during an open enrollment period, coverage begins on the following January 1.
- For people enrolling because of a qualified life event, coverage begins on the first of the month following the qualified life event. Newborn dependents are added on date of birth, pending required documentation confirming eligibility.

How You Pay for Coverage

Your contribution for coverage is generally deducted from your pay on a before-tax basis. IRS regulations currently require that contributions for covering your domestic partner and his or her children are deducted from your pay on an after-tax basis.

Your ID Card

You will receive an ID card when you enroll in the Plan. Be sure to keep your ID card handy and show it to medical providers before you receive services and to network pharmacies when you purchase prescription drugs.

If your card is lost or stolen, please notify Aetna immediately. You can either call Aetna Member Services or log on to your secure member website at **www.aetna.com** to request a replacement.

Benefit Resources and Tools

Resources

When you have questions or need more information, here are some of the resources available to you.

Resource	Situation	How to Contact
Carilion Human Resources Department	Contact your Human Resources representative when: • You have a qualified life event • You need to report a change in your name, address or telephone number	Phone: 1-800-599-2537 Online: **https://insidecarilion.org**
Aetna Member Services	Contact Member Services when: • You have questions about the Plan's medical or prescription drug benefits • You have a question about a claim	Medical Benefits: Phone: 1-800-633-0635 Prescription Drug Benefits Phone: 1-855-786-6879
Carilion Clinic Pharmacy	Use when you need: • To fill a prescription for maintenance medication • Specialty medications • Mail order program	Carilion Clinic Pharmacy: Carilion Roanoke Memorial Hospital Phone: 540-266-6480 Crystal Spring Phone: 540-583-0905 New River Valley Phone: 540-639-1647 Riverside Phone: 540-526-1450
Aetna Navigator® Your Secure Member Website	Use your member website when you need: • Eligibility or claim status information • A replacement ID card • Copies of claim forms • Access to tools that help you manage your health care	Online: **www.aetna.com**

Resource	Situation	How to Contact
Informed Health® Line	Call the Informed Health Line when you are looking for information about: • Medical procedures and treatment options • Asking the right questions when talking with your health care provider	Phone: 1-800-556-1555 TDD: 1-800-270-2386

Tools

Online Provider Directory

DocFind® is Aetna's online provider **directory**. DocFind gives you information on the doctors, hospitals and other providers in the network. You can learn about a provider's credentials and practice, including education, board certification, languages spoken, office location and hours, and parking and handicapped access.

To access DocFind, go to **www.aetna.com/docfind/custom/carilion** and follow the prompts.

Health Information Website

Use your secure member website at **www.aetna.com** as your online resource for personalized benefit and health information. Once registered, you'll have access to secure, personalized features, such as benefit and claim status, as well as specific health and wellness information:

- Request a replacement ID card;
- Download copies of claim forms;
- Check the status of a claim;
- Find benefit balances; and
- Contact Aetna Member Services.

You also have access to useful tools that help you manage your health care, such as:

- *Aetna SmartSource™,* a search engine that scans Aetna's online resources and pulls together information that's specific to you – based on where you live, the plan you've enrolled in and your personal profile. Just enter a condition or symptom and SmartSource will give you links to useful information, such as:
  - The names of doctors in the network who specialize in treating a condition;
  - Estimated health care costs;

  - Programs and discounts that may help you with your health care needs;
  - Health articles and tips.
- *Simple Steps To A Healthier Life*®, an online wellness program that offers information and self-help tools for weight loss, stress management and fitness. When you visit the program's site, you can complete a Health Risk Assessment and receive a personalized action plan with recommended healthy living programs based on your personal health needs.

Aetna Mobile

After you register for your secure member website, you can download the free Aetna Mobile app. You can use it to:

- Find an in-network doctor of facility
- View your ID card
- Look up claims
- View your Personal Health Record

Aetna mobile works with Apple® and Android™ mobile devices. Text "Apps" to 44040 to download the free app.

How the Plan Works

You can choose any doctor or health care provider when you need care. But the Plan only pays benefits for medically necessary covered expenses. This SPD outlines and describes many of the medical, vision, hearing and prescription drugs that the plan pays benefits for.

You must be covered by the Plan on the date you incur a covered medical expense. The Plan does not pay benefits for expenses incurred before your coverage starts or after it ends.

A **necessary** medical service, supply or prescription drug is ordered or given by a doctor or other health care provider to prevent, evaluate or treat an illness, injury or disease or its symptoms.

The Provider Network

How care is covered and how much you pay out of your own pocket depends on whether the expense is covered by the Plan and whether you choose:

- A Level A provider in the Carilion network,
- A Level B provider in the Aetna network; or
- A Level C out-of-network provider.

Aetna and Carilion network providers include:

- Primary care doctors (general and family practitioners, pediatricians, internists and Ob/Gyns);
- Specialists (such as, surgeons, cardiologists and urologists); and
- Health care facilities (such as hospitals, skilled nursing facilities and diagnostic testing labs).

Network providers agree to provide services or supplies at **negotiated charges**. If you use an in-network provider, you'll pay less out of your own pocket for your care. You also won't have to fill out claim forms, because your in-network provider will file claims for you.

To find an in-network Carilion or Aetna provider in your area:

- *Use DocFind at* **www.aetna.com/docfind/custom/carilion**. Follow the prompts to search for a specific doctor, type of doctor, or all the doctors in a given zip code and/or travel distance. (Out-of-network providers will not be listed in DocFind.)
- *Call Member Services*. Member Services representatives can help you find an in-network provider in your area. The Member Services toll-free number is printed on your ID card.

Primary Care

The Plan does not require you to choose a primary care physician (PCP). However, we encourage you and each covered member of your family to select an internist, family care practitioner, general practitioner or pediatrician (for your children) to serve as your regular PCP. A PCP can be your personal health care manager. He or she gets to know you and your special needs and problems, and can recommend a specialist when you need care that he or she can't provide.

The Summary of Benefits shows how the Plan's level of coverage differs when you use Carilion or Aetna in-network versus out-of-network providers.

Key Terms

The following are key terms of the Plan:

Necessary Services and Supplies

The Plan pays benefits only for medically **necessary** services and supplies.

Negotiated Charge

Aetna **in-network providers** have agreed to charge no more than the negotiated charge for a service or supply that is covered by the Plan. You are not responsible for amounts over the negotiated charge when you get care from a provider in the network.

Non-Occupational Coverage

The Plan only covers expenses for a **non-occupational injury** or **non-occupational disease**. In other words, the Plan will not pay for expenses due to a work-related illness or injury.

If your out-of-network provider charges more than the recognized charge, you will pay for any charges that are above the recognized charge amount.

Recognized Charge

The Plan pays out-of-network benefits for recognized charges only. The part of a charge that is not recognized is not covered.

Refer to the Glossary for more information about how Aetna determines the recognized charge for a service or supply.

Sharing the Cost of Care

In addition to the premiums you pay from each paycheck, you share in the cost of your medical care by paying deductibles, copays and coinsurance. These terms are explained below.

Copay (copayment)

A **copay**, or copayment, is a fee that you must pay at the time you receive some types of care.

The Summary of Benefits shows which services are subject to a copay.

Inpatient Facility Copay

When you are admitted to a hospital you pay the first part of your covered expenses a per confinement copay.

A separate copay applies for each admission. (If another admission is made within 10 days of the prior admission, then another copay does not apply.)

Deductible

The **deductible** is the part of covered expenses you pay each calendar year before the Plan starts to pay benefits.

There are separate deductibles for Carilion network, Aetna network and out-of-network care.

- Expenses that apply to the Carilion or Aetna network deductible do not apply toward the out-of-network deductible.
- Expenses that apply to the out-of-network deductible do not apply toward Carilion or Aetna deductible.

> **Note**
> Charges applied to the in-network deductible do not reduce the out-of-network deductible and vice versa.

There are two types of calendar year deductible:

- *Individual*: The individual deductible applies separately to each covered person in the family. When a person's deductible expenses reach the individual deductible shown in the Summary of Benefits, the person's deductible is met. The Plan then starts to pay benefits for that person at the appropriate coinsurance percentage.
- *Family*: The family deductible applies to the family as a group. When the combined deductible expenses of all covered family members reach the family deductible shown in the Summary of Benefits, the family deductible is met. The Plan then begins to pay benefits for all covered family members.

> **Note**
> The overall family deductible limit can be met through a combination of deductible expenses applied to all covered individuals.

Coinsurance

Once you meet your deductible, the Plan begins paying benefits for covered expenses. The portion paid by the Plan, shown in the Summary of Benefits, is the Plan's coinsurance. When the Plan's coinsurance is less than 100%, you pay the balance. The part you pay is called your coinsurance.

The Plan has different coinsurance levels for Carilion and Aetna in-network and out-of-network care for each type of covered expense. Refer to the Summary of Benefits charts for more information.

Out-of-Pocket Maximum

The Plan puts a limit on the amount you pay for covered expenses out of your own pocket each year. This is called the **out-of-pocket maximum**.

After you reach the individual and/or family out-of-pocket maximum, you are not responsible for any copayments for the rest of the year.

- The individual out-of-pocket maximum applies separately to each covered person in the family. Once a family member reaches the individual out-of-pocket maximum shown in the Summary of Benefits, the Plan pays 100% of that person's covered medical expenses for the rest of the calendar year.
- The family out-of-pocket maximum applies to the family as a group. When your family's combined out-of-pocket expenses satisfy the family out-of-pocket maximum, the Plan pays 100% of the family's covered medical charges for the remainder of the calendar year.

The Plan has separate out-of-pocket maximums for in-network and out-of-network care:

- Expenses that apply to the in-network out-of-pocket maximum do not apply toward the out-of-network out-of-pocket maximum.
- Expenses that apply to the out-of-network out-of-pocket maximum do not apply toward the in-network out-of-pocket maximum.

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

- If you see an out-of-network provider or use an out-of-network facility, expenses over the **recognized charge**;
- Charges for services and supplies that are not covered by the Plan.

In an Emergency

You have coverage 24 hours a day, 7 days a week, anywhere in the world, if you need care to treat an **emergency condition**.

An emergency medical condition is a recent and severe condition, sickness or injury, including (but not limited to) severe pain, that would lead a prudent layperson (including the parent or guardian of a minor child or the guardian of a disabled individual), possessing an average knowledge of medicine and health, to believe that failure to get immediate medical care could result in:

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

Examples of medical emergencies include:	
• heart attack or suspected heart attack • poisoning or suspected poisoning • severe shortness of breath • uncontrolled or severe bleeding	• loss of consciousness • suspected overdose of medication • severe burns • high fever (especially in an infant)

What the Plan Covers

This section includes details about the services and supplies that are covered by the Plan. Remember, the Plan only covers services and supplies that are **necessary** to diagnose or treat an illness or injury. If a service or supply is not necessary, it will not be covered, even if it is listed as a covered expense in this book.

The Plan pays benefits for covered expenses only. The benefit level for each type of covered expense is shown in the Summary of Benefits.

Some expenses are not covered by the Plan. Examples of expenses not covered are listed in this section and also in the section titled What the Plan Does Not Cover.

Preventive Care

These preventive care services are covered:

Routine Physical Exams

The Plan does not pay benefits for exams for school or work or for exams needed to take part in school sports programs. Also, the Plan does pay for immunizations needed only for travel.

The Plan covers charges for routine physical exams. Covered as part of the exam are:

- X-rays, lab services and other tests given relating to the exam
- Immunizations for infectious diseases and the materials needed to administer the immunizations
- Testing for tuberculosis

The exam must be given by a doctor or under the direction of a doctor.

If an exam is given to diagnose or treat an injury or disease, it is ***not*** considered a routine physical exam.

The Summary of Benefits shows how the Plan will pay benefits for a routine physical exam.

What Is Not Covered as Part of a Routine Physical Exam

- Medicines, equipment or supplies
- Immunizations needed only for travel or employment
- Psychiatric, psychological, personality, or emotional testing or exams
- Premarital exams

Screening and Counseling

Preventive care includes charges made by your doctor for the following in an individual or group setting:

- Screening and counseling services to help you lose weight if you are obese. Coverage includes:
  - Preventive counseling visits;
  - Medical nutrition therapy;
  - Nutritional counseling; and
  - Healthy diet counseling visits for those with high cholesterol and other known risk factors for heart and diet-related chronic disease.
- Screening and counseling services to help you stop using tobacco products. A tobacco product is 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.
- Screening and counseling services to help prevent or reduce the use of alcohol or controlled substances. Coverage includes:
  - Preventive counseling visits;
  - Risk factor reduction intervention; and
  - A structured assessment.
- Human Immune Deficiency Virus (HIV) screening and counseling services.

Preventive care coverage also includes the following services for women:

- Screening and counseling services for:
  - Interpersonal and domestic violence;
  - Sexually transmitted diseases (up to two occurrences per year); and
  - Human Immune Deficiency Virus (HIV).
- High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- Screening for gestational diabetes.

Visit maximums are shown in the Summary of Benefits**.**

Routine Cancer Screenings

The Plan covers:

- One baseline mammogram for women age 35 to 39, and one mammogram each calendar year for women age 40 and over; and

- One digital rectal exam (DRE) and prostate specific antigen (PSA) test per calendar year for men age 40 and over.

Beginning at age 50, the Plan covers the following tests when recommended by your doctor:

- One fecal occult blood stool test per calendar year.
- For those at average risk for colorectal cancer:
  - One colonoscopy every 10 years; or
  - One sigmoidoscopy every 5 years; or
  - One double contrast barium enema every 5 years.

Routine Ob/Gyn Exams

The Plan covers one annual routine ob/gyn exam, including one Pap smear and related lab fees.

Vision and Hearing Services

Routine Eye Exams

Routine eye exams by an ophthalmologist or optometrist are covered. The Plan covers one exam every calendar year.

Routine Hearing Exams

An audiometric hearing exam is covered when it is given by:

- An otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association; and
  - Performs the exam at the written direction of an otolaryngologist or otologist.

The Plan does not cover:

- Any hearing device or service that does not meet professionally accepted standards;
- Hearing exams given during your stay in a hospital or other facility; or
- Any tests, appliances and devices to:
  - Improve hearing, including hearing aids and amplifiers;
  - Improve other forms of communication to offset hearing loss; or
  - Simulate speech.

Office Visits and Walk-In Clinics

Office Visits

The Plan covers treatment in a doctor's office. The Plan pays different benefits for physician and specialist office visits. Refer to the Summary of Benefits chart for details.

Walk-In Clinics

A **walk-in clinic** is a free-standing health care facility. The Plan covers visits to walk-in clinics for non-emergency treatment of an illness or injury, and for administration of certain immunizations.

Family Planning and Maternity

Voluntary Sterilization

The Plan covers charges made by a doctor or **hospital** for a vasectomy or tubal ligation. The Plan does ***not*** cover the reversal of a sterilization procedure.

Contraception Services

The Plan covers the following contraceptive services and supplies when obtained from, and billed by, your doctor:

- Contraceptive counseling.
- Contraceptive devices prescribed by a physician.
- Office visit for the injection of injectable contraceptives.
- Related outpatient services such as consultations, exams and procedures.

Other contraceptives may be covered as part of the prescription drug program. Refer to the section of this book describing the Prescription Drug Program for more information.

Infertility Services

The Plan covers the diagnosis and treatment of the underlying cause of infertility, including:

- Initial evaluation, including history, physical exam and laboratory studies performed at an appropriate laboratory;
- Evaluation of ovulatory function;
- Ultrasound of ovaries at an appropriate participating radiology facility;
- Post-coital test;
- Hysterosalpingogram;

- Endometrial biopsy; and
- Hysteroscopy.

Limits

The Plan does ***not*** cover:

- Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of a sterilization procedure;
- Advanced reproductive therapies – IVF, GIFT, ZIFT, cryopreserved embryo transfers, ICSI and ovum microsurgery
- Purchase of donor sperm;
- Storage of sperm;
- Purchase of donor eggs;
- Care of the donor required for donor egg retrievals or transfers;
- Cryopreservation or storage of cryopreserved eggs or embryos;
- All charges associated with gestational carrier programs, for either the covered person or the gestational carrier;
- Home ovulation prediction kits;
- Infertility services for covered females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- Infertility services that are not reasonably likely to be successful;
- Services received by a spouse or partner who is not covered by the Plan.

The Plan covers certain infertility services when ***all*** the following tests are met:

- A woman has a condition that:
  - Is a proven cause of **infertility**; and
  - Has been recognized by a gynecologist or infertility **specialist**; and
  - Is not caused by voluntary sterilization or a hysterectomy; or
- A man has a condition that:
  - Is a proven cause of infertility; and
  - Has been recognized by a urologist or infertility specialist; and
  - Is not caused by voluntary sterilization and/or a vasectomy.
- The procedures are performed on an outpatient basis.
- Follicle-stimulating hormone (FSH) levels are less than 19 mIU/ml on day 3 of the menstrual cycle.

- The woman can't become pregnant through less costly treatment that is covered by the Plan.

Maternity Care

The Plan covers prenatal, delivery and postnatal maternity care. In accordance with the Newborns' and Mothers' Health Protection Act, the Plan covers inpatient care of the mother and newborn child for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.

The Plan does not cover childbirth at home or in a place that is not licensed to perform deliveries.

If you and your doctor agree to an earlier discharge from the hospital, the Plan will pay for one home visit after delivery by a health care provider.

Precertification is not required for the first 48 hours of hospital confinement after a vaginal delivery or 96 hours after a cesarean delivery. Any days of confinement over these limits must be precertified. You, your doctor or another health care provider can request precertification by calling the number on your ID card.

Birthing Center

The Plan covers prenatal, delivery and postnatal maternity care given by a birthing center. Postnatal care must be given within 48 hours after a vaginal delivery, or 96 hours after a cesarean section.

Breast Feeding Support, Counseling and Supplies

The Plan covers:

- Breast feeding help, training and counseling services by a certified lactation support provider in a group or individual setting.
- Initial purchase of a standard (not hospital-grade) electric breast pump or manual breast pump during pregnancy or while breast feeding.
- Purchase of the accessories needed to use the breast pump.
- For each pregnancy that follows:
  - Purchase of a replacement manual breast pump.
  - Purchase of a replacement standard electric breast pump, if:
    - you have not purchased a standard electric pump within the past three years; or
    - the initial electric pump is broken or out of warranty.
  - Purchase of a new set of breast pump supplies.

Hospital Care

Inpatient Hospital Care

The Plan covers charges made by a **hospital** for **room and board** when you are an inpatient. Room and board charges are covered up to the hospital's **semi-private room rate**.

Other services and supplies provided during your inpatient stay are covered, such as:

- Ambulance services when the service is owned by the hospital;
- Physician and surgeon services;
- Operating and recovery rooms;
- Intensive or special care facilities;
- Administration of blood and blood products, but not the cost of the blood or blood product itself;
- Radiation therapy;
- Physical, occupational and speech therapy;
- Cardiac and pulmonary rehabilitation;
- Oxygen and oxygen therapy;
- X-rays, lab tests and diagnostic services;
- Medicines;
- Intravenous (IV) preparations; and
- Discharge planning.

Keep in Mind

- The Plan does not cover private room charges that are more than the hospital's semi-private room rate unless a private room is medically **necessary** because of a contagious illness or immune system problems.
- If a hospital does not itemize charges, Aetna will assume that 40 percent of the total is for room and board and 60 percent is for other charges.
- Some physicians and other providers may bill you separately for services given during your hospital stay. If you receive services from a radiologist, anesthesiologist or pathologist who is not in the Aetna network during an inpatient stay at an in-network facility, the Plan will cover those services at the in-network benefit level. Services of other out-of-network providers will be covered at the out-of-network benefit level, even if the hospital is an in-network hospital.

Outpatient Hospital Care

The Plan covers charges made by a hospital for services and supplies provided on an outpatient basis.

Pre-Admission Testing

The Plan covers *outpatient* testing done by a hospital, surgery center, doctor or before a covered surgical procedure, if the tests:

- Are related to surgery that will take place in a hospital or surgery center;
- Are completed within 14 days of your surgery;
- Would be covered if you were an inpatient in a hospital; and
- Are included in your medical record kept by the hospital or surgery center where the surgery takes place.

The tests are covered only if they are not repeated in or by the hospital or surgery center where the surgery will take place.

Keep in Mind

If your tests show that surgery should not be done because of your physical condition, the Plan covers the tests, but not the proposed surgery.

Surgery

The Plan covers the charges made by a doctor for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultations with another doctor for a second opinion prior to the surgery.

Keep in Mind

- You may need to have more than one surgical procedure done at the same time or during a single operating session. The Plan normally pays a lower percentage of the fees that are charged for the secondary procedure(s).
  The Plan does ***not*** cover any surgery that is not medically necessary, even if performed with another procedure that is necessary.
- Pre-operative and post-operative visits by your surgeon are considered to be part of the surgical fee. The Plan does ***not*** cover separate fees for pre-operative and post-operative care.
- Surgery performed by a physician who is not in the Aetna network will be covered as out-of-network care and subject to recognized charge limits . . . even if the surgery is performed in an in-network hospital.

Anesthesia

The Plan covers the administration of anesthetics and oxygen by a **physician** (other than the operating physician) or Certified Registered Nurse Anesthetist (CRNA) in connection with a covered procedure.

Acupuncture

The Plan covers acupuncture given by a physician as a form of anesthesia in connection with a covered surgical procedure.

Bariatric Surgery

The Plan covers inpatient or outpatient charges made by a **hospital** or doctor for the medically **necessary** surgical treatment of **morbid obesity**.

Coverage includes one morbid obesity surgical procedure, including related outpatient services, within a two-year period that starts with the date of the first surgical procedure to treat morbid obesity, unless a multistage procedure is planned.

> **Keep in Mind**
> The Plan does not cover bariatric surgery when done for cosmetic reasons.

Refer to Aetna's Clinical Policy Bulletins to learn more about coverage for weight loss surgery. You can find the CPBs at **www.aetna.com**.

Oral Surgery

The Plan covers treatment of accidental injury to natural teeth and oral surgery that is considered medical in nature.

> **Medical or Dental?**
> Oral surgery that is medical in nature is typically covered by the medical plan. It involves:
>
> - Disease of the facial bones
> - Trauma to the soft and hard tissue structures of the face and oral cavity
> - Correcting facial deformities present at birth or later
>
> Surgery that is dental in nature involves the teeth. Tooth surgery is typically covered by a dental plan.

The Plan covers:

- Hospital services and supplies for an inpatient hospital stay required because of your condition.
- Services of a doctor or **dentist** for treatment of the following conditions of the teeth, mouth, jaws, jaw joints or supporting tissues if medically necessary:
  - Surgery necessary to treat a fracture, dislocation or wound;

  - Surgery necessary to alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot improve function;
  - Surgery necessary to cut out cysts, tumors or other diseased tissues;
  - Surgery to cut into gums and tissues of the mouth, as long as this is not done in connection with the removal, replacement or repair of teeth; and
  - Non-surgical treatment of infections or diseases not related to the teeth.
- Treatment of accidental injury to sound natural teeth or tissues of the mouth. The treatment must be given in the calendar year of the accident or in the following calendar year. The teeth must have been free from decay or in good condition, and firmly attached to the jaw bone at the time of the injury.

- The Plan's coverage of dentures, bridgework, crowns and appliances is limited to:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown (cap) needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

If not covered to treat accidental injury, the Plan does ***not*** cover charges:

- For dental-in-nature oral surgery expenses;
- For in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of those services or supplies is to relieve pain;
- For root canal therapy;
- To remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- To repair, replace or restore fillings, crowns, dentures or bridgework;
- For dental cleaning, in-mouth scaling, planing or scraping; or
- For myofunctional therapy. This is muscle training therapy or training to correct or control harmful habits.

Outpatient Surgery

The Plan covers outpatient surgery in:

- An office-based surgical facility;

- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery is covered only if it:

- Can be performed adequately and safely only in a surgery center or hospital; and
- Is not normally performed in a physician's or dentist's office.

The Plan covers the following outpatient surgery expenses:

- Services and supplies provided by the hospital, surgery center or office-based surgical facility on the day of the procedure;
- The operating physician's services for performing the procedure, related pre- and post-operative care, and the administration of anesthesia; and
- Services of another physician for related post-operative care and the administration of anesthesia (other than a local anesthetic).

The Plan does ***not*** cover the services of a physician who provides technical assistance to the operating physician**.**

Reconstructive Surgery

The Plan covers reconstructive and cosmetic surgery if the surgery is needed:

- To improve a significant functional impairment of a body part.
- To repair an accidental injury that happens while you are covered by the Plan. The surgery must be performed in the calendar year of the accident or the following calendar year. This time period may be extended for a child through age 18.
- To repair an accidental injury that occurred during a covered surgical procedure. The corrective surgery must be performed within 24 months after the original injury.
- To correct a severe anatomical defect present at birth (or appearing after birth) if the defect has caused:
  - Severe facial disfigurement; or
  - Significant functional impairment, and the purpose of the surgery is to improve function.
- As part of reconstruction following a mastectomy.

Gender Reassignment Surgery

The Plan covers medically necessary sex reassignment surgery when:

- You are at least 18 years old;
- You have met the diagnosis of "true" transsexualism, as determined by Aetna; and

- Any significant medical or mental health concerns are reasonably well controlled.

Medically necessary core surgical procedures include:

- For female to male reassignment: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty and placement of testicular prostheses, and erectile prostheses.
- For male to female reassignment: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty.

Cosmetic Surgery Is Not Covered

The Plan does not cover cosmetic services and supplies related to sexual reassignment:

- Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords) and skin resurfacing used in feminization are considered cosmetic.
- Chin implants, nose implants, and lip reduction to assist masculinization are considered cosmetic.

For more information, refer to Aetna's Clinical Policy Bulletins at **www.aetna.com.**

Transplants

If You Need a Transplant

Call Aetna Member Services when you and your physician begin to discuss transplant services. Member Services can answer benefit questions, help you find an in-network provider, tell you about the services offered by the National Medical Excellence Program and refer you to the Special Case Customer Service Unit to start the transplant authorization process.

The Plan's transplant coverage includes (but is not limited to) the following transplants:

- Bone marrow/stem cell
- Heart
- Heart/lung
- Intestine
- Kidney
- Liver
- Lung
- Pancreas
- Simultaneous pancreas/kidney

In general, there are four phases in the transplant process:

- Initial evaluation and screening. This phase includes evaluation and acceptance into a transplant facility's transplant program.

- Candidacy screening. This phase includes compatibility testing of prospective organ donors who are immediate family members.
- Transplant event. This phase includes obtaining an organ, surgical procedures and medical therapies related to the transplant.
- Follow-up care. During this phase, you may need home health care services, home infusion services and other outpatient care.

A transplant coverage period begins at the point of evaluation for a transplant and ends on the later of:

- 180 days from the date of the transplant; or
- The date you are discharged from a hospital or outpatient facility for the admission or visit(s) related to the transplant.

The Plan covers:

- Evaluation.
- Compatibility testing of prospective organ donors who are immediate family members.
- Charges for activating the donor search process with national registries.
- The direct costs of obtaining the organ. Direct costs include surgery to remove the organ, organ preservation and transportation, and the hospitalization of a live donor, provided that the expenses are not covered by the donor's group or individual health plan.
- Physician or transplant team services for transplant expenses.
- Hospital inpatient and outpatient supplies and services, including:
  - Physical, speech and occupational therapy;
  - Biomedicals and immunosuppressants;
  - Home health care services; and
  - Home infusion services.
- Follow-up care.

As part of the transplant benefit, the Plan does ***not*** cover:

- Services and supplies provided to a donor when the recipient is not covered by this Plan;
- Outpatient drugs, including biomedicals and immunosuppressants, that are not expressly related to an outpatient transplant occurrence;
- Home infusion therapy after the transplant coverage period ends;

- Harvesting or storage of organs without the expectation of an immediate transplant for an existing illness;
- Harvesting or storage of bone marrow, tissue or stem cells without the expectation of a transplant to treat an existing illness within 12 months; or
- Cornea or cartilage transplants unless otherwise preauthorized by Aetna.

Aetna offers a wide range of support services to those who need a transplant or other complex medical care. If you need a transplant, you or your physician should contact Aetna's National Medical Excellence Program® at **1-877-212-8811**. A nurse case manager will provide the support that you and your physician need to make informed decisions about your care.

Refer to Special Programs for more information about the National Medical Excellence Program.

The Institutes of Excellence™ Network

You have access to Institutes of Excellence™ (IOE) network - a provider network that specializes in transplants. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

The Plan covers transplants at the following benefit levels:

Carilion Network and IOE Network	Aetna Network	Out-of-Network
You pay 10% after deductible ***and*** $500 copay; Plan pays 90%	You pay 50% after deductible ***and*** $500 copay; Plan pays 50%	Not covered

Other Inpatient Care

Skilled Nursing Facility

The Plan covers charges for the following made by a **skilled nursing facility** during an inpatient stay, up to the maximum shown in the Summary of Benefits:

- **Room and board charges**, up to the **semi-private room rate**. The Plan covers up to the private room rate if it is needed because of an infectious illness or a weak or compromised immune system.
- General nursing services.
- Use of special treatment rooms.
- Radiology services and lab work.
- Oxygen and other gas therapy.

Keep in Mind

Skilled nursing facility coverage does not include treatment of drug addiction, alcoholism, senility, mental retardation or any other mental illness.

Home Health Care

The Plan covers home health care ordered by a doctor and given to you under a **home health care plan** while you are homebound. Coverage includes:

- Part-time nursing care given by an RN or by an LPN if an RN is not available. The services must be provided during occasional visits of four hours or less.
- Part-time home health aide services given in direct support of care by an RN or LPN. The services must be provided during intermittent visits of four hours or less.
- Medical social services by a qualified social worker given in direct support of care by an RN or LPN.
- Medical supplies, medicines and lab services given by (or for) a **home health care agency**. Coverage is limited to what would have been covered if you had stayed in a hospital.

Keep in Mind

- The Plan does not cover **custodial care**, even if the care is provided by a nurse, and family members or other caretakers cannot provide the necessary care.
- Physical, speech and occupational therapy given as part of a home health care plan are subject to the maximum for short-term rehabilitation shown in the Summary of Benefits.
- The Plan does not cover care that isn't part of a home health care plan.

Hospice Care

The Aetna Compassionate Care℠ Program offers support to those facing the advanced stages of an illness. Refer to Special Programs for more information.

The Plan covers hospice care for a person who is **terminally ill**.

The following charges from a hospice facility, **hospital** or **skilled nursing facility** are covered:

- Semi-private room and board and other services and supplies given for pain and other symptoms.
- Outpatient services and supplies.

The Plan covers charges made by a **hospice care agency** for:

- Part-time or intermittent nursing care by an **RN** or **LPN** for up to eight hours in a day.
- Part-time or intermittent home health aide services for up to eight hours in a day. These services consist mainly of caring for the patient.
- Medical social services under a physician's direction.
- Psychological and dietary counseling.
- Consultation or case management services provided by a **physician**.
- Physical and occupational therapy.
- Medical supplies.
- Respite care to relieve primary caregivers.
- Bereavement counseling.

The hospice care benefit does ***not*** cover:

- Private or special nursing services.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling, including estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services not entirely related to the care of a patient and include sitter or companion services for the patient or other family members, transportation, housecleaning and home maintenance.

Private Duty Nursing

The Plan covers private duty nursing by an **RN** or **LPN** if a person's condition requires **skilled nursing services** and visiting nursing care is not enough.

The Plan pays benefits up to the maximum shown in the Summary of Benefits. A shift consists of up to 8 hours of skilled nursing care.

The Plan also covers skilled observation after:

- A change in your medication;
- Treatment of an emergency or urgent medical condition;
- The onset of symptoms that indicate the need for emergency treatment;
- Surgery; or
- A hospital stay.

Coverage for skilled observation is limited to one four-hour period per day, for up to 10 days.

The Plan does ***not*** cover:

- Any care that does not require the education, training and skills of an RN or LPN. This would include transportation, meal preparation, charting of vital signs and companionship.
- Inpatient private duty nursing care.
- Help with activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting.
- Providing oral medicines, except where the law requires that it be given by an RN or LPN.

Emergency and Urgent Care

Emergency Care

The Plan covers **emergency care** for an emergency condition that is given in a hospital emergency room or a free-standing emergency facility.

The emergency care benefit covers:

- Use of emergency room facilities;
- Emergency room physician services;
- Hospital nursing staff services; and
- Radiology and pathology services.

Urgent Care

The Plan covers the services to evaluate and treat an **urgent condition**. **Urgent care providers** are physician-staffed facilities offering unscheduled medical services.

The urgent care benefit covers:

- Use of urgent care facilities;
- Physician services;
- Nursing staff services; and
- The services of radiologists and pathologists.

Ambulance

The Plan covers charges made for a professional ambulance**.** Coverage depends upon the type of vehicle used:

Ground Ambulance

The Plan covers ambulance transport:

- To the first hospital where treatment is given during an emergency;
- From one hospital to another hospital when the first hospital does not have the required services or facilities for your condition;
- From hospital to home or to another facility when an ambulance is medically necessary for safe and adequate transport; and
- From a hospital or skilled nursing facility stay to receive medically necessary inpatient or outpatient treatment if required for safe and adequate transport.

Air or Water Ambulance

In a medical emergency, transport by air or water ambulance from one hospital to another hospital is covered if:

- The first hospital does not have the required services or facilities for your condition; and
- Ground ambulance is not appropriate because of the distance, or your condition is unstable and requires medical supervision and rapid transport.

Other Covered Expenses

This section describes other covered expenses for both inpatient and outpatient care. The Plan's standard level of benefits applies to these expenses, unless shown otherwise.

Chemotherapy

Coverage for chemotherapy depends on where you receive treatment:

- In most cases, chemotherapy is covered as outpatient care.
- The Plan covers the initial dose of chemotherapy given in the hospital when:
  - You have been hospitalized for the diagnosis of cancer; and
  - A hospital stay is necessary based on your health status.

Diabetic Supplies

The Plan covers supplies used to treat insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy:

- External insulin pumps;
- Foot care to minimize the risk of infection;
- Glucagon emergency kits;

- Alcohol swabs;
- Foot orthotics and orthopedic shoes;
- Injection aids.

Before going for complex imaging, X-rays or lab services, check on whether the outpatient facility is in the network. Services from an out-of-network facility will be covered at the out-of-network level…*even if your tests were ordered by an in-network doctor*.

Diagnostic Complex Imaging

The Plan covers complex imaging to diagnose an illness or injury, including:

- Computerized axial tomography (CAT) scans;
- Magnetic Resonance Imaging (MRI); and
- Positron Emission Tomography (PET) scans.

Diagnostic X-Ray and Laboratory (DXL) Procedures

The Plan covers **necessary** X-rays, laboratory services and pathology tests to diagnose an illness or injury.

Durable Medical Equipment

The Plan covers the rental of durable medical equipment, up to the limits shown in the Summary of Benefits. Examples of equipment include wheelchairs, crutches, hospital beds and oxygen for home use. The Plan covers only one item for the same (or a similar) purpose, plus any needed accessories.

Instead of rental, the Plan may cover the purchase of equipment if:

- It either can't be rented or would cost less to buy than to rent; and
- It will be used long term.

The Plan also covers the charges to maintain or fix equipment when necessary. Repairs needed because of misuse or abuse are not covered.

Experimental or Investigational Services

In general, the Plan does ***not*** cover drugs, devices, treatments or procedures that are **experimental or investigational**. But the Plan will cover care that is considered experimental or investigational if it meets ***all*** the following conditions:

- You have been diagnosed with cancer or a condition likely to cause death within one year;
- 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;
- 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 U.S. Food and Drug Administration or the Department of Defense) and conforms to 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.

Habilitation Therapy Services

The Plan covers the following outpatient habilitation therapy services that are ordered by a doctor for children to age 6.

The services must be given by:

- A licensed or certified physical, occupational or speech therapist; or a provider certified by the Behavior Analyst Certifying Board (BACB);
- A hospital;
- A home health care agency; or
- A physician.

Covered services include:

- Physical therapy if it is expected to develop an impaired function.
- Occupational therapy that is expected to develop an impaired function, (except for vocational rehabilitation, employment counseling, and therapy provided in an educational or training setting).
- Up to 30 speech therapy visits (except for services provided in an educational or training setting, or to teach sign language), provided that the therapy is expected to:
  - improve delays in the development of speech function as a result of a gross anatomical defect present at birth; or
  - develop speech function.
- Applied behavioral analysis (except for educational services that are part of a personal Education Plan), provided that:

Speech function is the ability to express thoughts, speak words and form sentences.

- it conforms to the process of applying interventions that are based on the principles of learning derived from experimental psychology research to systematically change behavior and to demonstrate that the interventions used are responsible for the observable improvement in behavior; and
- ABA methods are used to increase and maintain desirable adaptive behaviors, reduce interfering maladaptive behaviors or narrow the conditions under which they occur, teach new skills, and generalize behaviors to new environments or situations.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services provided in your home if you are homebound.

Inpatient Habilitation

Inpatient habilitation services will be covered as part of your inpatient hospital and skilled nursing facility benefits.

Infusion Therapy

Infusion therapy is the intravenous or continuous administration of medicines. The Plan covers outpatient infusion therapy given by:

- A clinic;
- The outpatient department of a hospital; or
- A doctor in his/her office or in your home.

Coverage includes:

- The medicine;
- Any medical supplies, equipment, and nursing services needed to support the therapy;
- Total parenteral nutrition;
- Chemotherapy;
- Drug therapy, including antibiotics and antivirals;
- Pain management; and
- Hydration therapy, including fluids, electrolytes and other additives.

Limits

The following are not covered as infusion therapy:

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

Outpatient Radiology

The Plan covers radiology services provided by a doctor, hospital or licensed radiology lab to diagnose an illness or injury.

Outpatient Short-Term Rehabilitation

Physical, Occupational and Speech Therapy

The Plan covers outpatient short-term rehabilitation services when prescribed by a doctor and given by:

- A licensed or certified physical, occupational or speech therapist; or a practitioner certified by the Behavior Analyst Certifying Board (BACB);
- A hospital;
- A home health care agency; or
- A physician.

Covered therapy includes:

- Cognitive therapy associated with physical rehabilitation when the cognitive deficits are 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.
- Physical therapy (except for services provided in an educational or training setting), provided that the therapy is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure.
- Occupational therapy (except for vocational rehabilitation, employment counseling and services provided in an educational or training setting), provided that the therapy is expected to:
  - significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure; or
  - help the patient relearn skills that significantly improve independence in the activities of daily living.
- Speech therapy (except for services provided in an educational or training setting, or to teach sign language), provided that the therapy is expected to:

- significantly improve or restore the speech function or correct a speech impairment as a result of an acute illness, injury or surgical procedure; or
- improve 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.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services provided in your home if you are homebound.

Inpatient Therapy

Inpatient rehabilitation services will be paid as part of your inpatient hospital and skilled nursing facility benefits.

The Plan limits benefits for physical, occupational and speech therapy to the maximum shown in the Summary of Benefits.

Cardiac and Pulmonary Rehabilitation

The Plan covers:

- Outpatient cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The services must be part of a treatment plan based on your risk level and recommended by your physician. The Plan covers up to 36 sessions in a 12-week period.
- Outpatient pulmonary rehabilitation to treat reversible pulmonary disease. The Plan covers up to 36 hours or a six-week period of therapy.

Prosthetics

The Plan covers prosthetic devices and special appliances. The device or appliance must improve or restore the function of a body part that was lost or damaged by illness, injury or congenital defect.

Here are some examples of covered devices:

- An artificial arm, leg, hip, knee or eye;
- An eye lens;
- An external breast prosthesis and the first bra made solely for use with the prosthesis after a mastectomy;
- A breast implant after a mastectomy; and

- A cardiac pacemaker.

Coverage includes:

- Purchase of the first prosthesis that you need to temporarily or permanently replace an internal body part or organ, or an external body part.
- Instruction and incidental supplies needed to use a covered prosthetic device.
- Replacement of a prosthetic device if:
  - The replacement is needed because of a change in your physical condition or because of normal growth or wear and tear;
  - Replacement is likely to cost less than repairing the existing device; or
  - The existing device cannot be made serviceable.

Radiation Therapy

The Plan covers the treatment of illness by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Spinal Manipulation (Chiropractic Care)

The Plan covers chiropractic care of a condition caused by (or related to) biomechanical or nerve conduction disorders of the spine. Care must be given by a doctor or licensed chiropractor in their office.

Behavioral Health Care

Refer to the Glossary for the definitions of effective treatment of alcohol or substance abuse or a mental disorder that is covered.

The Plan includes coverage for behavioral health care.

To be covered, the care must be for:

- The **effective treatment of alcohol or substance abuse**; or
- The **effective treatment of a mental disorder**.

Inpatient Care

The Plan covers inpatient services in a **hospital**, **psychiatric hospital** or **residential treatment center** when your condition requires an inpatient stay. Coverage includes:

- **Room and board charges**, up to the facility's **semi-private room rate**; and
- Other necessary services and supplies.

Partial Confinement

The Plan covers charges made by a hospital or psychiatric hospital for **partial confinement treatment** through a day care or night care treatment program. The charges will be covered as outpatient care.

Care is covered only if needed treatment is only available in a partial confinement treatment setting or if you would need inpatient care if you were not participating in this type of program.

Outpatient Treatment

The Plan also covers the effective treatment of mental disorders or alcohol or substance abuse on an outpatient basis.

Limits

The Plan does ***not*** cover charges for:

- Administrative psychiatric services when these are the only services rendered.
- Bereavement counseling.
- Biofeedback.
- Confrontation therapy.
- Consultations with a mental health professional for adjudication of marital, child support and custody cases.
- Court-mandated or legally mandated treatment that is not considered **necessary**, as determined by Aetna, or that would not otherwise be covered by the Plan.
- Ecological or environmental medicine, diagnosis or treatment.

- Educational evaluation/remediation therapy or school consultations.
- Erhard Seminar Training (EST) or similar motivational services.
- Expressive therapies (art, poetry, movement, psychodrama).
- Hypnosis and hypnotherapy.
- Lovaas therapy.
- Marriage, family, child, career, social adjustment, religious, pastoral or financial counseling.
- Mental and psychoneurotic disorders not listed in the International Classification of Diseases, Ninth Revision (ICD-9).
- Mental health treatment for weight reduction or control.
- Primal therapy.
- Psychological counseling related to changing sex or sexual characteristics.
- Psychodrama.
- Stand-by services required by a physician.
- Telephone consultations.
- Transcendental meditation.
- Therapies for the treatment of delays in development, unless resulting from acute illness or injury or congenital defects that are amenable to surgical repair (such as cleft lip or palate), or as described in Short-Term Rehabilitation. For example, the Plan does not cover treatment for the following diagnoses, because they are considered both developmental and/or chronic in nature:
  - Down syndrome.
  - Cerebral palsy.
- Treatment of antisocial personality disorder.
- Treatment of impulse control disorders such as:
  - Caffeine or nicotine use;
  - Kleptomania;
  - Pathological gambling; or
  - Pedophilia.
- Treatment of health care providers who specialize in mental health and receive treatment as part of their training in that field.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or to medical treatment for someone who is mentally incapacitated.

- Treatment of sexual addiction, co-dependency or any other behavior that does not have a DSM-IV diagnosis.
- Wilderness programs.

Prescription Drug Plan

Prescription drugs that are to be taken on an outpatient basis are covered under the prescription drug plan. (Drugs that you need while you are confined in a **hospital** or other health care facility may be covered as part of your inpatient medical benefits.)

Three Copay Levels

The prescription drug plan has three copay levels (tiers). The amount you pay for your prescription depends on whether the drug is:

- A generic drug or a brand name drug; and
- On Aetna's Preferred Drug List.

The Summary of Benefits shows the copay that applies to each tier:

- Tier one – generic drugs
- Tier two – brand name drugs that are on the Preferred Drug List
- Tier three – brand name drugs that are not on the Preferred Drug List

Generic and Brand-Name Drugs

To save money, choose generic drugs. Generic drugs are approved by the U.S. Food and Drug Administration, which means that a generic drug has the same quality, strength and effectiveness as the brand-name equivalent. You can ask your doctor for a generic drug or ask your pharmacist if there is a generic drug that is equal to the brand name drug your doctor prescribed.

What is the Preferred Drug List?

The Preferred Drug List, which is also known as the formulary, shows the generic and brand name drugs that are considered preferred because of their overall ability to meet members' needs at a reasonable cost. You can reduce your copayment by using a covered generic drug (tier one) or a covered brand-name drug (tier two) that appears on the list. Your copayment will be highest if your doctor prescribes a brand-name drug that is not on the Preferred Drug List (tier three).

Find Aetna's Preferred Drug List online at www.aetna.com You can also call Member Services at the number on your ID card to request Preferred Drug List information.

Retail Pharmacy

Carilion Clinic Pharmacy

You may fill your **prescriptions that are not considered maintenance mediciations** for up to a 30-day supply at a Carilion Clinic pharmacy or another pharmacy.

Just show your ID card at the pharmacy and pay the copay shown in the Summary of Benefits. You will not need to file a claim when using a Carilion Clinic pharmacy.

Other Pharmacy

You also may fill prescriptions that are not considered maintenance medications at other pharmacies. You do need to file a claim when using other pharmacies. See the section of this book entitled Claims and Appeals for more information.

Specialty Pharmacy

Those with chronic medical conditions may need medicines that may require special storage and handling or sometimes have side effects that must be carefully watched.

Specialty medications covered only if they are received through these Carilion Clinic pharmacies:

- Carilion Clinic Pharmacy – Crystal Spring
- Carilion Clinic Pharmacy – New River Valley
- Carilion Clinic Pharmacy – Riverside
- Carilion Clinic Pharmacy – Carilion Roanoke Memorial Hospital

Maintenance Medication Program

Maintenance medications (medications taken daily such as those for asthma, blood pressure and birth control) must be filled at a Carilion Clinic Retail Pharmacy using the 90-day refill option. For a 90-day supply, you typically pay less than or equal to the price of two months.

Covered Drugs

The Plan covers:

- Federal legend drugs (drugs that require a label stating: “Caution: Federal law prohibits dispensing without prescription”) or any other drug which under the applicable state law may be dispensed only upon the written prescription of a **physician**.
- Compounded medication, of which at least one ingredient is a federal legend drug.

- Contraceptives:
  - Oral contraceptives.
  - Injectable contraceptives such as Depo Provera.
  - Contraceptive devices.
  - Patches.
  - Contraceptive implants and IUDs (when obtained from a physician who provides insertion and removal of the drugs or device).
  - Rings.
  - Over the counter FDA-approved contraceptives for women, including sponges, spermicides and female condoms, when purchased at an in-network pharmacy. You must have a prescription from your physician.
- Diabetic needles and syringes.
- Insulin.
- Over-the-counter diabetic supplies.

Preventive Drugs

The Plan covers100% of the cost of the following, with no copay or deductible, when purchased at an in-network pharmacy:

- Aspirin to prevent heart disease for those age 45 or older.
- Oral fluoride for children age 6 months through age 5.
- Vitamin D for those age 65 and older.
- Folic acid supplements for women.

You must have a prescription from your physician.

What the Prescription Drug Program Does Not Cover

The exclusions that apply to the medical plan (see What the Plan Does Not Cover) also apply to the prescription drug program. There are also other exclusions that apply to the prescription drug plan. The prescription drug plan does ***not*** cover:

- Administration or injection of any prescription drug.
- Allergy sera and extracts.
- Any drug dispensed by a mail-order pharmacy other than Aetna Rx Home Delivery.
- Any drug taken when and where it is prescribed.
- Any drug that does not, by federal or state law, require a prescription, such as an over-the-counter drug or equivalent over-the-counter product, even when a prescription is written for it.

- Any refill of a drug dispensed more than one year after the latest prescription for it, or as prohibited by law where the drug is dispensed.
- Biological sera, blood, blood plasma, blood products or substitutes, or any other blood products.
- Devices of any type (such as a spacer or nebulizer) used with a prescription drug. Note that some devices may be covered as **durable medical equipment** or as part of another medical plan benefit.
- Durable medical equipment, monitors and other equipment.
- Drugs to treat erectile dysfunction:
- Experimental or investigational drugs or devices. This exclusion will not apply to drugs that:
  - Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or
  - Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
  - Aetna determines, based on available scientific evidence, are effective or show promise of being effective for the illness.
- Food items, including infant formula, nutritional supplements, vitamins (including prescription vitamins), medical foods and other nutritional items, even when the item is the only source of nutrition.
- Any treatment, device, drug or supply to alter the body's genes, genetic make-up or the expression of the body's genes, except for the correction of congenital birth defects.
- Vaccines or immunological agents unless provided at a Carilion Clinic Pharmacy.
- Infertility treatment. The Plan does not cover drugs used to primarily treat infertility, including drugs for, or related to, artificial insemination, in vitro fertilization or embryonic transfer procedures.
- Inpatient drugs: Any drug provided by a health care facility or while you are an inpatient there. Also, any drug provided on an outpatient basis by a health care facility if benefits are paid for it under any other part of this Plan or another plan sponsored by your employer.
- More than the number of refills specified by the prescribing doctor. Aetna may require a new prescription or proof of need if the **prescriber** has not specified the number of refills or if the frequency or number of refills seems excessive under accepted medical practice standards.

- Non-emergency prescription drugs bought outside of the United States if:
  - You travel outside of the U.S. to obtain the prescription drugs or supplies, even if they would be covered by the Plan if purchased in the U.S.;
  - The drugs or supplies are unavailable or illegal in the U.S.; or
  - The purchase of these drugs or supplies outside of the U.S. is illegal.
- Weight loss and weight gain drugs, including (but not limited to) stimulants, preparations, foods, diet supplements, dietary regimens and appetite suppressants.

What the Plan Does Not Cover

The Plan does not cover all medical expenses; certain expenses are excluded. The following is a list of *some* expenses that are not covered. Just because a type of medical treatment or an expense is not listed here does not mean that the treatment or expense will be covered by the Plan.

General Exclusions

The Plan does ***not*** cover charges:

- For cancelled or missed appointments.
- For care, treatment, services or supplies:
  - Given by an unlicensed provider; or
  - Outside the scope of the provider's license.
- For care, treatment, services or supplies not prescribed, recommended or approved by a doctor or dentist.
- For claim form completion.
- For drugs, devices, treatments or procedures that are **experimental or investigational**, except as described in What the Plan Covers.
- For services and supplies Aetna determines are not **necessary** to diagnose or treat a disease or injury – even if they are prescribed, recommended or approved by a doctor or dentist.
- For services from volunteers or people who do not normally charge for their services.
- For services and supplies provided as part of treatment or care that is not covered by the Plan.
- For services and supplies provided in camp infirmaries.
- For services and supplies that are related to injuries, illnesses or conditions suffered due to the acts or omissions of a third party
- For services of a resident physician or intern.
- For services, supplies, medical care or treatment given by members of your immediate family (your spouse, domestic partner, child, step-child, brother, sister, in-law, parent or grandparent) or your household.
- Incurred before the date coverage starts or after the date coverage ends.
- In excess of the **recognized charge** for a service or supply given by an **out-of-network provider**.

- In excess of the **negotiated charge** for a given service or supply given by an **in-network provider**.
- Made only because you have health coverage or that you are not legally obligated to pay, such as:
  - Care in charitable institutions; or
  - Care in a hospital or other facility that is owned or operated by any government, except to the extent coverage is required by law.
- Related to employment or self-employment. This includes injuries that arise from any work for pay or profit, unless there is no other source of coverage or reimbursement available to you.

Alternative Health Care

The Plan does ***not*** cover charges for:

- Acupuncture, acupuncture therapy and acupressure, except when performed by a physician as a form of anesthesia for surgery covered by the Plan.
- Alternative or non-standard allergy services and supplies, including (but not limited to):
  - Cytotoxicity testing (Bryan's Test);
  - Skin titration (Rinkel method);
  - Treatment of non-specific candida sensitivity; and
  - Urine autoinjections.
- Aromatherapy.
- Bioenergetic therapy.
- Carbon dioxide therapy.
- Herbal medicine.
- Megavitamin therapy.
- Massage therapy.
- Rolfing.
- Thermography and thermograms.

Biological

The Plan does ***not*** cover charges for:

- Blood, blood plasma, synthetic blood, blood products or blood substitutes, including (but not limited to) the provision of blood, other than blood derived clotting factors. The Plan does not cover any related services, including:
  - Processing, storage or replacement costs; or

- The services of blood donors, apheresis or plasmapheresis.

  For autologous blood donations, only administration and processing costs are covered.

- Growth hormones, surgical procedures or any other treatment, device, drug, service or supply used solely to increase or decrease height or alter the rate of growth.

Cosmetic Procedures

The Plan does ***not*** cover the following, regardless of whether the service is provided for psychological or emotional reasons:

- Plastic surgery;
- Reconstructive surgery, except as described under Reconstructive Surgery;
- Cosmetic surgery; or
- Other services, treatments or supplies that improve, alter or enhance the shape or appearance of the body.

Custodial and Protective

The Plan does ***not*** cover charges for:

- Any item or service that is primarily for the personal comfort and convenience of you or a third party.
- Care provided to create an environment that protects a person against exposure that can make his or her disease or injury worse.
- Care, services and supplies provided in a:
  - Rest home;
  - Assisted living facility;
  - Health resort, spa or sanitarium; or
  - Similar institution serving as an individual's primary residence or providing primarily custodial or rest care.
- **Custodial care** – care provided to help a person in the activities of daily life.
- Maintenance care.
- Removal from your home, work place or other environment of potential sources of allergy or illness, including:
  - Asbestos or fiberglass;
  - Carpeting or paint;
  - Dust, pet dander or pests; or
  - Mold

Dental Care

The Plan does ***not*** cover services, treatment or supplies related to the care, filling, removal or replacement of teeth, including:

- Apicoectomy (dental root resection), root canal therapy, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty.
- Application of fluoride and other substances to protect, clean or alter the appearance of teeth.
- Dental implants, false teeth, plates, dentures, braces, mouth guards or other devices to protect, replace or reposition teeth.
- Non-surgical treatments to alter bite or the alignment or operation of the jaw, including:
  - Treatment of malocclusion; and
  - Devices to alter bite or alignment.

Education and Training

The Plan does ***not*** cover charges for:

- Services or supplies related to education, training, retraining services or testing, including:
  - Special education;
  - Remedial education;
  - Job training; or
  - Job hardening programs.
- Services, treatment, and education testing or training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Family Planning and Maternity

The Plan does ***not*** cover:

- Home uterine activity monitoring.
- Over-the-counter contraceptive supplies, including (but not limited to) condoms and contraceptive foams, jellies and ointments.
- Reversal of sterilization procedures.

Government and Armed Forces

The Plan does ***not*** cover charges – to the extent allowed by law – for services or supplies provided, paid for, or for which benefits are provided or required:

- Because of a person's past or present service in the armed forces of a government.
- Under any government law.

Health Exams

The Plan does ***not*** cover exams (including the presentation and preparation of any related reports) that are required:

- By any government law.
- By a third party, including exams to obtain or maintain employment, or which an employer must provide under a labor agreement.
- To obtain professional or other licenses.
- To obtain insurance.
- To travel; attend a school, camp or sporting event; or participate in a sport or other recreational activity.

Home and Mobility

The Plan does not cover alterations changes or additions to your home, work place or other area, or any related equipment or device, including:

- Bathroom equipment such as tub seats, benches, rails and lifts.
- Equipment or supplies to help you sit or sleep, such as electric beds, water beds, air beds, warming or cooling devices, elevating chairs and reclining chairs.
- Exercise and training devices, whirlpools, sauna baths, massage devices or over-bed tables.
- Purchase or rental of air purifiers, air conditioners, water purifiers or swimming pools.
- Room additions or changes to countertops, doorways, lighting, wiring or furniture.
- Stair glides, wheelchair ramps and elevators.

The Plan does not cover vehicles and transportation devices, or adjustments to any vehicle or transportation device, including:

- Automobiles, vans or trucks.
- Bicycles.

- Stair-climbing wheelchairs.
- Personal transporters.

Prescription Drugs

The medical Plan covers prescription drugs provided while you are a hospital inpatient. Refer to the Prescription Drug Program section for information about other coverage for prescription drugs.

Refer to the Prescription Drug Program section for information about coverage for prescription drugs from a retail pharmacy.

The medical Plan does ***not*** cover:

- Any prescription drug you obtain on an outpatient basis.
- Any prescription drug obtained illegally outside of the U.S., even if covered when purchased in the U.S.
- Drugs used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.
- Immunizations related to travel or work.
- Implantable drugs and associated devices, except those for contraception.
- Injectable drugs, if an oral alternative is available.
- Needles, syringes and other injectable aids, except as covered for diabetic supplies.
- Over-the-counter drugs, biologicals or chemical preparations that can be obtained without a prescription.
- Performance-enhancing steroids.
- Self-injectable drugs.
- Services related to the dispensing, injection or application of a drug.
- Treatment, drug, service or supply to:
  - Stop or reduce smoking or the use of other tobacco products; or
  - Treat or reduce nicotine addiction, dependence or cravings.

  This exclusion includes (but is not limited to) counseling, hypnosis, medications, patches and gum.

Family Planning and Sexual Health

The Plan does ***not*** cover charges for:

- Drugs to treat erectile dysfunction, impotence, or sexual dysfunction or inadequacy, whether delivered in oral, injectable or topical forms. These include, but are not limited to:
  - Alprostadil (Muse, Edex, Caverject);
  - Phenotolamine;

- Sildenafil citrate (Viagra);
- Tadalafil (Cialis);
- Vardenafil (Levitra); and
- Any other drug in a similar or identical class that has a similar or identical mode of action or produces similar or identical outcomes.

This exclusion applies whether or not the drug is delivered in oral, injectable or topical forms (including but not limited to gels, creams, ointments and patches).

- Therapy, supplies or counseling for sexual dysfunction or inadequacies with no physiological or organic basis.
- Treatment, drugs, services or supplies to treat sexual dysfunction, enhance sexual performance or enhance 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 sexual organ; and
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services.

Short Term Rehabilitation Services and Habilitation Services

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Applied Behavior Analysis

Unless outlined in *What the Plan Covers*, the Plan does ***not*** cover:

- Educational services;
- Any services unless provided in accordance with a specific treatment plan;
- Any services that are covered expenses in whole or in part under any other group plan sponsored by an employer;
- Services provided during a stay in a hospital, skilled nursing facility or hospice facility except as stated in *What the Plan Covers*;
- Services provided by a home health care agency;
- Services provided by a chiropractor or treatment covered as part of the chiropractic Treatment;
- Services not performed by a physician, occupational or physical therapist, or a practitioner certified by the Behavior Analyst Certifying Board (BACB) or under the direct supervision of a physician;

- Services provided by a physician or physical or occupational therapist, or a practitioner certified by the Behavior Analyst Certifying Board (BACB) who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
- Special education to instruct a person to function. This includes lessons in sign language.

Outpatient Speech Therapy

Unless specified in *What the Plan Covers*, the Plan does not cover:

- Any services that are not given according to a specific treatment plan;
- Speech therapy services given during a stay in a hospital, skilled nursing facility or hospice facility;
- Services provided by a home health care agency;
- Services not given by a doctor or speech therapist or under the direction of a doctor;
- Services from a physician or speech therapist who lives in your home; is a member of your family, or a member of your spouse's or your domestic partner's family; and
- Special education to teach a person with lost or impaired speech how to function without that ability. This includes lessons in sign language.

Strength and Performance

The Plan does not cover services, devices and supplies to enhance your strength, physical condition, endurance or physical performance, including:

- Drugs or preparations to enhance strength, performance or endurance.
- Exercise equipment.
- Lifestyle enhancement drugs or supplies.
- Memberships in health or fitness clubs.
- Training, advice or coaching.
- Treatments, services and supplies to treat illness, injury or disability related to the use of performance-enhancing drugs or preparations.

Tests and Therapies

The Plan does ***not*** cover charges for:

- Full-body CAT scans.
- Hair analysis.
- Hyperbaric therapy, except to treat decompression or promote healing of a wound.
- Sleep therapy.

Vision, Speech and Hearing

The Plan does ***not*** cover charges for:

- Anti-reflective coatings and tinting of eyeglass lenses.
- Contact lenses.
- Eyeglasses, including duplicate or spare glasses, lenses or frames.
- Eye surgery to correct vision, including radial keratotomy, LASIK and similar procedures.
- Fitting of glasses or contact lenses for any purpose other than after cataract surgery.
- Hearing aids and their fitting, and hearing aid therapy or training.
- Replacement of lenses or frames that are lost, stolen or broken.
- Special services, such as non-prescription sunglasses and subnormal vision aids.
- Vision services mainly to correct refractive errors.
- Visual perceptual training.

Weight Control Services

Regardless of the existence of comorbid conditions, the Plan does not cover charges for weight control, except as described in Bariatric Surgery or the Screening and Counseling section of Preventive Care. The Plan does ***not*** cover charges for:

- Weight control/loss programs;
- Dietary regimens and supplements;
- Appetite suppressants and other medications;
- Food or food supplements; or
- Exercise programs or equipment.

Special Programs

The discount and health management programs described in this section support a healthy lifestyle and offer help in case of a serious illness.

Health Management Programs

Online Health Assessment

Simple Steps to a Healthier Life® can help you be your healthiest. This personalized online health and wellness program offers resources to help you eat better, lose weight, get in shape, relieve stress and more.

This program features:

- An online *health assessment* to help you identify your health needs;
- Personalized *health reports* and a one-page *health summary* to share with your doctor, based on your completed assessment; and
- A personalized *action plan* recommending online programs and interactive tools in areas such as nutrition, fitness, stress relief and smoking cessation – chosen for you based on your health needs.

Tailor the program to meet your needs and lifestyle by choosing the resources that are right for you. Simple Steps to a Healthier Life is secure, so your information is protected and confidential. To get started, log in to your secure member website at **www.aetna.com**.

Disease Management

Aetna Health Connections℠ disease management program is designed to make it easier for you to manage your conditions and live your life well. The program offers you educational materials and online resources – plus nurse case management for those at high risk – for more than 30 conditions, including asthma, diabetes, certain cancers and arthritis.

Aetna Health Connections can help you:

- Understand your treatment options and how to follow your doctor's treatment plan;
- Better manage your ongoing conditions;
- Identify and manage your risks for other conditions; and
- Make changes to reach your personal health goals.

What You Need to Do

If you have a condition supported by the program, or if you think you are at risk of developing a condition, submit a request to participate through your secure member website at **www.aetna.com** or by calling **1-866-269-4500**. Participation is voluntary.

Advanced Illness Resources

The Aetna Compassionate Care℠ program offers service and support when you are facing difficult decisions about an advanced illness or hospice. The program's nurse case managers work with doctors to:

- Arrange for care and manage benefits;
- Find resources for the patient and family members; and
- Help family members and other caregivers manage the patient's pain and symptoms.

What You Need to Do

Call Aetna Member Services at the number on your ID card to talk with a nurse case manager about the Aetna Compassionate Care program. Online support is also available at **www.aetnacompassionatecare.com**.

Transplant and Special Medical Care

The National Medical Excellence Program® (NME) can help you get care and helpful resources when you need it most – with one-on-one support through all phases of treatment. The program includes:

- *National Transplant Program* – coordinates care and provides access to covered treatment through the *Institutes of Excellence™ Transplant Network*.
- *National Special Case Program* – assists members with rare or complex conditions requiring specialized treatment to evaluate treatment options and obtain appropriate care.
- *Out-of-Country Care Program* – supports members who need emergency inpatient medical care while temporarily traveling outside the United States.

These services must be preauthorized by Aetna.

When NME arranges for treatment at a facility more than 100 miles from your home, the Plan provides travel and lodging allowances for you and one **companion,** including round trip (air, train or bus) transportation costs (coach class only) or mileage, parking and tolls if traveling by auto.

Benefits for travel and lodging expenses are subject to a maximum of $10,000 per transplant or procedure. Lodging expenses are subject to a $50 per night maximum per person, or $100 per night total.

The Plan will pay for travel and lodging expenses beginning on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest of the following dates:

- One year after the day a covered procedure was performed; or
- On the date you cease to receive any services from the program provider in connection with the covered procedure; or
- On the date your coverage terminates under the Plan.

Keep in Mind

- The Plan covers only those services, supplies and treatments considered necessary for your medical condition. The Plan does ***not*** cover treatment considered **experimental or investigational** (as determined by Aetna).
- Travel and lodging expenses must be approved in advance by Aetna. The Plan does ***not*** cover expenses that are not approved.

The Aetna Discount Program

The **Aetna Discount Program** offers you discounts on many products and services for your health, wellness and life.

What You Need to Do

Visit your secure member website at **www.aetna.com** to learn more about these discounts.

Type of Product or Service	Offers discounts on:
At home products	Products and services for home and family such as: blood pressure monitor, apparel, toys, financial and legal services
Books	Books, CDs, DVDs, videos, family reading, magazine subscriptions, gifts
Fitness	Gym memberships, home fitness products, fitness plans, sports equipment
Hearing	Hearing exams, hearing aids, batteries, repairs and other hearing aid services
LifeMart® shopping website	Travel, tickets, electronics, home, auto, family care, groceries, wellness, dining, food
Natural products and services	Acupuncture, chiropractic, over-the-counter vitamins, online medical consultations, spa and yoga, skincare
Oral health care	Water-jet flossers, cavity-fighting gum, toothpaste, mouthwash, mints
Vision	Eye exams, frames, lenses, contact lenses and solutions, sunglasses, LASIK surgery
Weight management	Weight loss programs and products, diet and meal plans, magazine subscriptions

When Coverage Ends

Fast Facts

Plan coverage for an employee ends when any of the following occurs:

- The employee no longer meets the Plan's eligibility requirements;
- The Plan is terminated; or
- Employment ends.

Coverage for dependents ends when:

- The employee's coverage ends;
- The employee is no longer eligible for dependent coverage;
- The dependent no longer meets the Plan's definition of an eligible dependent; or
- All dependent coverage under the Plan ends.

In the event of a divorce, coverage for a spouse ends at the end of the month following the date of the divorce.

Coverage for your domestic partner ends when:

- The Plan no longer provides coverage for domestic partners; or
- Your domestic partnership ends. You must give Human Resources a completed and signed Declaration of Termination of Domestic Partnership.

Options for Continuing Coverage

You may be able to continue coverage after it would otherwise end. See Continuing Plan Coverage Under COBRA for more information.

Leaves of Absence

You may be able to continue coverage during a leave of absence. The rules vary based on the reason for the leave.

Family and Medical Leave Act

Through the Family and Medical Leave Act (FMLA), you may request up to 12 work weeks of leave during any 12-month period:

- For the birth or adoption of a child; or
- For a serious health condition affecting you or a family member.

You may request up to 26 weeks of leave during a 12-month period if you are the spouse, child, parent or next of kin of a service member who is recovering from a serious illness or injury sustained in the line of duty while on active duty. The 26-week limit is combined for all FMLA leaves in the 12-month period.

During FMLA leave, your Plan coverage continues as long as you continue making your contributions.

If your employer terminates your FMLA leave, and you lose Plan coverage as a result, you may be eligible to continue coverage under COBRA. See Continuing Plan Coverage Under COBRA for more information.

Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) allows qualified employees to continue their enrollment in the Plan for up to 24 months when they are called to active duty for more than 31 days.

You may continue Plan coverage during your military leave until the earlier of:

- 24 months (terms are similar to COBRA); or
- The date you fail to return to work as outlined by USERRA.

If you do not continue coverage for you or your family members during your leave and you return to work:

- You and your family members will again be covered on the date you return to work from your military leave, if you apply at that time (this requires you to return to work as outlined by USERRA);
- Any eligibility waiting period not completed earlier will not be credited during your leave; and
- Any condition that begins during the leave will not be considered a pre-existing condition if you return as outlined by USERRA.

You will be given credit for the time you were covered under the Plan before your military leave, as well as credit for any/all of the 24-month continuation period, when elected.

What You Need to Do

Check with the Carilion Human Resources Department for more information about family and medical or military leaves.

Continuing Coverage

When Plan coverage would normally end, you or your covered dependents may be able to continue coverage in certain circumstances. This section describes how you or your covered dependents may be able to temporarily continue coverage.

Continued Coverage for a Handicapped Child

If your child is handicapped, the child's health care coverage may be continued past the Plan's age limit for dependents.

Your child is considered handicapped if he or she is unable to earn a living because of a mental or physical handicap that starts before he or she reaches the age limit for dependent coverage.

Aetna will send you a letter before the child reaches the Plan's dependent age limit. The letter will include forms that you and the child's treating physician must complete to give Aetna proof of your child's handicap. You must complete and submit the forms no later than 30 days after your child reaches the dependent age limit. The child's coverage will end on the first to occur of the following:

- Your child is no longer handicapped;
- You fail to provide proof that the handicap continues;
- You fail to have any required exam performed; or
- Your child's coverage ends for a reason other than reaching the age limit.

Aetna has the right to require proof that the handicap continues. Aetna also has the right to examine your child as often as needed while the handicap continues. Once the child is two years beyond the Plan's dependent age limit, these exams will not be required more than once a year.

Continuing Plan Coverage under COBRA

If your employment ends for any reason other than for gross misconduct, or if you or your covered dependent is no longer eligible for coverage under the Plan, you and/or your covered dependent may temporarily continue coverage through the federal law known as COBRA. If you choose this continued coverage, you must do so within 60 days of a "COBRA event" that ends your coverage under this Plan. You pay the full cost of COBRA coverage, plus a 2% administration fee, on an after-tax basis. The full cost of coverage is different from the contribution you pay while you are working for the Company.

The chart below lists the reasons that coverage could end for you or your covered dependent. For each of those reasons, COBRA specifies the length of time that you may continue your Plan coverage.

	Maximum COBRA Continuation Period		
Reason Coverage Ended ("COBRA Event")	**You**	**Your Spouse**	**Your Child**
You lose coverage because of reduced work hours	18 months	18 months	18 months
Your employment terminates for any reason, other than for gross misconduct	18 months	18 months	18 months
You die	N/A	36 months	36 months
You become divorced or legally separated, or your marriage is annulled	N/A	36 months	36 months
You become entitled to Medicare	N/A	36 months	36 months
Your child reaches the Plan's age limit for dependent coverage	N/A	N/A	36 months

Being eligible for Medicare at the time of your COBRA event does not prevent you from electing COBRA coverage for yourself.

Extensions

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as described below.

Disability Extension

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

To be eligible for the 11-month extension, you or a family member must notify the Plan Administrator within 60 days of the SSA disability determination, and in no event later than the end of the first 18-month period of continuation coverage.

Second Qualifying Event

If you elect continuation coverage following a termination of employment or a reduction in hours and, during the 18-month period of continuation coverage, a second qualifying event occurs (other than a bankruptcy proceeding), your spouse and/or dependent child may extend his or her continuation coverage for a period of up to 36 months from the date the original COBRA coverage began.

Electing and Paying for COBRA Coverage

You pay the full cost of your Plan coverage when you elect COBRA coverage, plus a 2% administration fee. When you are eligible for COBRA coverage, you will be notified of its monthly cost.

When you are notified that you are eligible for COBRA coverage, you will have 60 days to elect that coverage. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your coverage began (the date of your COBRA event). During the 60-day election period, the Plan will, upon request, notify health care providers of your right to elect COBRA coverage, retroactive to the date of your COBRA event. Actual coverage will not begin until your first payment is received.

> **Will My COBRA Coverage Be the Same as My Coverage Today?**
>
> Yes. And any changes made to the Plan for active employees will also apply to you under COBRA.

While you are covered by the Plan under COBRA:

- You have the same rights as any other eligible employee – including the right to change your coverage election during the annual open enrollment.
- If you have another COBRA event or a qualified life event, as described in the section titled Qualified Life Event Changes, you may change your coverage election.
- If your dependent has another COBRA event while under the COBRA coverage period of 18 months, your dependent may qualify for an additional period of COBRA coverage, with the total COBRA coverage period limited to 36 months; you or your dependent must notify the COBRA administrator of the second COBRA event.

Notification of Your COBRA Rights

The Plan's COBRA administrator will notify you by mail of your right to elect COBRA coverage when your COBRA event is a reduction in hours or termination of employment. The notice will give you instructions on how to continue your plan coverage.

If your covered dependents lose coverage because of a divorce or loss of dependent status, you or your covered dependents must notify the Company within 60 days of the COBRA event, so that COBRA coverage may be offered and election rights can be mailed. The Plan will not provide continuation coverage if not notified within 60 days of the event.

To extend your COBRA coverage beyond 18 months because of eligibility for disability benefits from Social Security, notice of the Social Security Administration's determination must be provided within 60 days after you receive it, and before the end of your initial 18-month continuation period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown in the above chart if:

- You or your covered dependent becomes eligible for Medicare after electing COBRA.
- You or your covered dependent becomes covered under another group plan that does not restrict coverage for a pre-existing condition. If your new plan does have a restriction for pre-existing conditions:
  - Your COBRA continuation under this Plan can continue until the pre-existing condition restriction ends under the other plan; or
  - You reach the end of the maximum continuation period for this Plan.
- The first required premium is not paid.
- The Plan terminates.

Coordination with Other Plans

Effect of Another Plan on This Plan's Benefits

If you have coverage under other group plans or receive payments for an illness or injury caused by another person, the benefits you receive from this Plan may be adjusted. This may reduce the benefits you receive from this Plan. The adjustment is known as coordination of benefits (COB).

Benefits available through other group plans and/or no-fault automobile coverage are coordinated with this Plan. "Other group plans" include any other plan of dental or medical coverage provided by group insurance or any other arrangement of group coverage for individuals, regardless of whether that plan is insured.

To find out if benefits under this Plan will be reduced, Aetna must first use the rules listed below, in the order shown, to determine which plan is primary (pays its benefits first). The first rule that applies in the chart below will determine which plan pays first:

If . . .	**Then . . .**
1. One plan has a COB provision and the other plan does not	The plan without a COB provision determines its benefits and pays first.
2. One plan covers you as a dependent and the other covers you as an employee or retiree	The plan that covers you as an employee or retiree determines its benefits and pays first.
3. You are eligible for Medicare and actively working	These Medicare Secondary Payer rules apply: • The plan that covers you as an active employee pays first. • The plan that covers you as a dependent of a working spouse determines its benefits and pays next. • Medicare pays third.
4. A child's parents are married or living together (whether or not married)	The plan of the parent whose birthday occurs earlier in the calendar year determines its benefits and pays first. If both parents have the same birthday, the plan that has covered the parent the longest determines its benefits and pays first. But if the other plan does not have this "parent birthday" rule, the other plan's COB rule applies.
5. A child's parents are separated or divorced with joint custody, and a court decree does not assign	The "birthday rule" described above applies.

If . . .	Then . . .
responsibility for the child's health expenses to either parent, or states that both parents are responsible for the child's health coverage	
6. A child's parents are separated or divorced, and a court decree assigns responsibility for the child's health expenses to one parent	The plan covering the child as the assigned parent's dependent determines its benefits and pays first.
7. A child's parents are separated, divorced or not living together (whether or not they have ever been married) and there is no court decree assigning responsibility for the child's health expenses to either parent	Benefits are determined and paid in this order: a) The plan of the custodial parent pays, then b) The plan of the spouse of the custodial parent pays, then c) The plan of the non-custodial parent pays, then d) The plan of the spouse of the non-custodial parent pays.
8. You have coverage: • as an active employee (that is, not as a retired or laid-off employee) and also have coverage as a retired or laid-off employee; or • as the dependent of an active employee and also have coverage as the dependent of a retired or laid-off employee	The plan that covers you as an active employee or as the dependent of an active employee determines its benefits and pays first. This rule is ignored if the other plan does not contain the same rule. Note: this rule does not apply if rule 2 (above) has already determined the order of payment.
9. You are covered under a federal or state right of continuation law (such as COBRA)	The plan other than the one that covers you under a right of continuation law will determine its benefits and pay first. This rule is ignored if the other plan does not contain the same rule. Note: this rule does not apply if rule 2 (above) has already determined the order of payment.
10. The above rules do not establish an order of payment	The plan that has covered you for the longest time will determine its benefits and pay first.

When the other plan pays first, the benefits paid under this Plan are reduced as shown here:

- The amount this Plan would pay if it were the only coverage in place, *minus*
- Benefits paid by the other plan(s).

This prevents the sum of your benefits from being more than you would receive from just this Plan.

If your other plan(s) pays benefits in the form of services rather than cash payments, the Plan uses the cash value of those services in the calculation.

About Medicare

How This Plan Coordinates With Medicare Parts A and B

You are eligible for Medicare if you:

- Are eligible for, and covered by, Medicare;
- Are eligible for, but not covered by, Medicare because you:
  - Refused Medicare coverage;
  - Dropped Medicare coverage; or
  - Did not make a proper request for Medicare coverage.

If you are eligible for Medicare, as defined above, this medical plan assumes that you participate in Medicare Parts A and B. Therefore, you should enroll in Medicare Part B when you are first eligible. If you do not participate in Medicare Parts A and B, your coverage under this plan will not make up for lost Medicare benefits.

When This Plan Is Primary

This Plan is primary, and Medicare is secondary, if a covered person is eligible for Medicare and is:

- An active employee, regardless of age;
- A totally disabled employee who is:
  - Not terminated or retired; or
  - Not receiving Social Security retirement or Social Security disability benefits.
- A Medicare-eligible dependent spouse of:
  - An active employee; or
  - A totally disabled employee who is not terminated or retired.
- Any other person for whom this Plan's benefits are payable to comply with federal law.

When this Plan is the primary plan, Aetna will not take Medicare benefits into consideration when figuring the benefits payable by the Plan.

End-Stage Renal Disease

This Plan is primary for the first 30 months after a covered person becomes eligible for Medicare due to end-stage renal disease (ESRD). The Plan will pay benefits for a covered expense first, before Medicare benefits are available.

Medicare becomes the primary plan beginning with the 31st month of Medicare eligibility due to ESRD.

When Medicare Is Primary

Medicare is the primary plan, and this Plan is secondary, if a covered person is eligible for Medicare and is:

- A retired employee.
- A totally disabled employee who is:
  - Terminated or retired; or
  - Receiving Social Security retirement or Social Security disability benefits.
- A Medicare-eligible dependent of:
  - A retired employee; or
  - A totally disabled employee who is terminated or retired.
- Any other dependent for whom this Plan's benefits are payable to comply with federal law.

When Medicare is primary, this plan coordinates with Medicare as follows:

- Medicare pays benefits for the covered service first.
- After Medicare pays its share, this plan will pay according to its benefit provisions.

Health care expenses covered by this medical plan will be reduced by any Medicare benefits available for those expenses.

How Medicare Affects Your Plan Benefits

When Medicare is your primary plan, as described above, this Plan is secondary and pays benefits based on:

- *If the provider accepts Medicare assignment*: Medicare's approved amount for the service you've received; or
- *If the provider doesn't accept Medicare assignment*: Medicare's balance billing limit.

The Plan's benefit for a covered service is figured by:

- Calculating the allowable expense, depending on whether the provider accepts or does not accept Medicare assignment (see above); *then*
- Applying the Plan's deductible and coinsurance to the allowable expense; *then*
- Subtracting the amount payable by Medicare (even if you haven't signed up for Medicare and therefore haven't received Medicare reimbursement).

Keep in Mind

Once you are eligible for Medicare, the Plan's benefits are calculated as though you have enrolled in Part B – ***whether or not you've actually enrolled***. This is why it's important to enroll in Part B as soon as you become eligible for it.

Claims and Appeals

The Plan has a process to submit claims and file an appeal when you don't agree with a claim decision. You and Aetna must meet certain deadlines that are assigned to each step of the process, depending on the type of claim.

Types of Claims

To understand the claim and appeal process, you need to understand how claims are defined:

- *Urgent care claim:* A claim for medical care or treatment where delay could seriously jeopardize your life or health or your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the requested care or treatment.
- *Pre-service claim:* A claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care (precertification).
- *Concurrent care claim extension:* A request to extend a course of treatment that was previously approved.
- *Concurrent care claim reduction or termination:* A decision to reduce or terminate a course of treatment that was previously approved.
- *Post-service claim:* A claim for a benefit that is not a pre-service claim.

Keeping Records of Expenses

It is important to keep records of medical expenses for yourself and your covered dependents. You will need these records when you file a claim for benefits. Be sure you have this information for your medical records:

- Name and address of physicians;
- Dates on which each expense was incurred; and
- Copies of all bills and receipts.

Filing Claims

Because the Plan has engaged Aetna to provide claims administration, you must file your medical claims with Aetna.

If you use an out-of-network provider, you must file a claim to be reimbursed for covered expenses. You can obtain a claim form from Aetna Member Services by calling the number on the back of your ID card, or by going online at **www.aetna.com**. The form has instructions on how, when and where to file a claim.

File your claims promptly – ***the filing deadline is 90 days after the date you incur a covered expense***. If, through no fault of your own, you are unable to meet that deadline, your claim will be accepted if you file it as soon as possible. Claims filed more than two years after the deadline will be accepted only if you had been legally incapacitated.

You may file claims and appeals yourself or through an "authorized representative," who is someone you authorize in writing to act on your behalf. In a case involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

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

Physical Exams

Aetna has the right to require an exam of any person for whom precertification or benefits have been requested. The exam will be done at any reasonable time while precertification or a claim for benefits is pending or under review. The exam may be performed by a doctor or dentist Aetna has chosen, and it will be done at no cost to you.

Time Frames for Claim Processing

Aetna will make a decision on your claim.

- *If Aetna approves the claim,* Aetna will send you an Explanation of Benefits (EOB) that shows you how Aetna determined the benefit payment. Aetna will pay any health benefits to the service provider, unless you give Aetna different instructions when you file the claim.

  Keep in Mind

  You can receive your EOBs via U.S. Mail or electronically on your secure member web site. If you'd like to receive electronic EOBs, log on to Aetna Navigator at **www.aetna.com**, and follow the instructions to *Turn Off Paper* under *Claims*.

- *If Aetna denies your claim,* Aetna must give you a written notice of the denial. The chart below shows when Aetna must notify you that your claim has been denied.

Type of Claim	Aetna Must Notify You
Urgent care claim	As soon as possible, but not later than 72 hours The determination may be provided in writing, electronically or orally. If the determination has been provided orally, a written or electronic notification will be sent no later than 3 calendar days after the oral notification.
Type of Claim	**Aetna Must Notify You**
Pre-service claim	15 calendar days
Concurrent care claim extension	• Urgent care claim – as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours before the end of the approved treatment • Other claims – 15 calendar days
Concurrent care claim reduction or termination	With enough advance notice to allow you to appeal
Post-service claim	30 calendar days

Extensions of Time Frames

The time periods described in the chart may be extended, as follows:

- *For urgent care claims:* If Aetna does not have enough information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after you provide the additional information.
- *For non-urgent pre-service and post-service claims:* The time frames may be extended for up to 15 additional days for reasons beyond the Plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended.

  If an extension of time is needed because Aetna needs more information to process your post-service claim:

  - Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information.
  - Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier).

  If you do not provide the information, your claim will be denied.

Notice of Claim Denial

A claim denial is also called an adverse benefit determination. An adverse benefit determination is a decision Aetna makes that results in denial, reduction or termination of:

- A benefit; or
- The amount paid for a service or supply.

It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

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

Aetna will send you written notice of an adverse benefit determination. The notice will give you:

- The reason or reasons that your claim was denied.
- A reference to the specific plan provisions on which the denial was based.
  - If an internal rule, guideline, protocol or other similar criterion was relied upon to determine a claim, you'll either receive:
    - A copy of the actual rule, guideline, protocol or other criterion; or
    - A statement that the rule, guideline, protocol or other criterion was used and that you can request a copy free of charge.
  - If the denial is based on a plan provision such as medical necessity, experimental treatment, or a similar exclusion or limit, you'll either receive:
    - An explanation of the scientific or clinical judgment for the determination; or
    - A statement that you can receive the explanation free of charge upon request.
- A description of any additional material or information needed to perfect the claim and the reason why the material or information is necessary.
- An explanation of the Plan's claim review and appeal procedures, applicable time limits and a statement of your rights to bring a civil action under ERISA section 502(a) after completing all required levels of appeal.

- An explanation of the expedited claim review process for an urgent care claim. In the case of an urgent care claim, the Plan may notify you by phone or fax, then follow up with a written or electronic notice within three days after the notification.

Appealing a Medical Claim Decision

Three Steps in the Appeal Process

The Plan provides for two levels of appeal to Aetna, plus an option to seek external review:

- You must request your first appeal (level one) within 180 calendar days after you receive the notice of a claim denial.
- If you are dissatisfied with the outcome of your level one appeal to Aetna, you may ask for a second review (a level two appeal). You must request a level two appeal no later than 60 days after you receive the level one notice of denial.
- After you have exhausted the level one and level two appeal process, you may file a voluntary appeal for external review if your claim meets certain requirements. You must submit a request for external review within 123 calendar days of the date you receive a final denial notice.

How to Appeal a Claim Denial

Your level one and level two appeals may be submitted in writing or by making a phone call to Aetna Member Services. Your appeal should include:

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

Send your appeal to Aetna Member Services at the address shown on your ID card, or call Member Services at the toll-free telephone number shown on your ID card.

Based on the type of claim, Aetna must respond to your appeal within the time frames shown in the following chart:

Type of Claim	Level One Appeal	Level Two Appeal
Urgent care claim	36 hours	36 hours
Pre-service claim	15 calendar days	15 calendar days
Concurrent care claim extension	Treated like an urgent care claim or a pre-service claim, depending on the circumstances	Treated like an urgent care claim or a pre-service claim, depending on the circumstances
Post-service claim	30 calendar days	30 calendar days

The review will be performed by Plan personnel who were not involved in making the adverse benefit determination.

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

If the Level One and Level Two appeals uphold the original adverse benefit determination for a *medical* claim, you may have the right to pursue an external review of your claim. See External Review for details.

Exhaustion of Internal Appeals Process

Generally, you must complete all the Plan's appeal levels before asking for an external review or bringing an action in litigation. However, if Aetna (or the Plan or its designee) does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements. This is known as deemed exhaustion. When this occurs, you may proceed with external review or pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

Exception

There is an exception to the deemed exhaustion rule. You cannot submit your claim or internal appeal directly to external review if the rule violation was:

- Minor and not likely to influence a decision or harm you; and
- For a good cause or was beyond Aetna's or the Plan's (or its designee's) control; and
- Part of an ongoing good faith exchange between you and Aetna or the Plan; and
- Not part of a pattern or practice of violations by Aetna or the Plan.

If the claims procedures have not been strictly adhered to, you have the right to request a written explanation of the violation from Aetna or the Plan. Within 10 days after receiving your request, Aetna or the Plan will give you an explanation of the basis, if any, for asserting that the violation should not cause the internal claim and appeal process to be deemed exhausted. If an external reviewer or court rejects your request for immediate review on the basis that the Plan met the standards for the exception, you have the right to resubmit your claim and pursue the internal appeal of the claim.

External Review

You may file a voluntary appeal for external review of any final appeal determination that qualifies. An external review is a review of an adverse benefit determination by an external review organization (ERO).

If you file for a voluntary external review, any applicable statute of limitations will be tolled (suspended) 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.

> **Keep in Mind**
> You do not have to file for voluntary review. After you exhaust the Plan's two standard levels of appeal, you may pursue any available remedies under Section 502(a) of ERISA. Your decision to decline the voluntary review process is not considered a failure to exhaust your administrative remedies.

Claims That Qualify for External Review

You may request an external review of a rescission (coverage that was cancelled or discontinued retroactively) or a claim denial based on medical judgment if:

- You have exhausted the Plan's appeal process; or
- Aetna (or the Plan or its designee) has not strictly followed all claim determination and appeal requirements under federal law (except for minor violations).

A denial based upon your eligibility does not qualify for external review.

You must complete all of the levels of standard appeal before you can request an external review, except in a case of deemed exhaustion (see Exhaustion of the Internal Appeals Process for an explanation of deemed exhaustion). Your authorized representative may act on your behalf in filing and pursuing this voluntary appeal, subject to any Plan verification procedures.

Deadline for Requesting an External Review

You must submit a request for external review in writing, using the Request for External Review form. You can ask Member Services for a copy of the form. Submit the request within 123 calendar days of the date you receive a final denial notice. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

Any request for external review must be made in writing, except in the case of an urgent care medical claim, which can also be made orally.

Preliminary Review

Aetna will do a preliminary review of your request for an external review within five days of receiving the request. The preliminary review determines whether:

- You were covered under the Plan at the time the service was requested or provided;
- The adverse determination does not relate to eligibility;
- You have exhausted the internal appeals process (unless deemed exhaustion applies); and
- You have provided all paperwork necessary to complete the external review.

Aetna must notify you in writing of the results of the preliminary review within one business day after completing the review.

- If your request is complete but not eligible for external review, Aetna's notice will include the reasons why it is not eligible and provide contact information for the Employee Benefits Security Administration (toll-free number **1-866-444-3272**).
- If the request is not complete, Aetna's notice will describe the information or materials needed to make the request complete. Aetna must allow you to perfect the request for external review within the 123 calendar days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to ERO

If your request for external review is approved, Aetna will assign an accredited ERO to conduct the review. The ERO will notify you in writing that your request is eligible and accepted for review, and give you an opportunity to submit additional information that the ERO must consider when conducting the review.

A neutral, independent clinical reviewer, with appropriate expertise in the area in question, will review your material. The decision of the external reviewer is binding unless otherwise allowed by law.

The ERO will review all of the information and documents received within required time frames. In reaching a decision, the assigned ERO will not be bound by any decisions or conclusions reached during the Plan's claims and appeals process. The ERO will consider the following in reaching a decision, as appropriate:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you or your treating provider;
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the final decision within 45 days after receiving the request for external review. The ERO must deliver the final decision to you, Aetna and the Plan.

Expedited External Review

The Plan must allow you to request an expedited external review at the time:

- You receive an adverse benefit determination, if:
  - That determination involves a medical condition for which the timeframe for completing an expedited internal appeal (the standard level one and level two appeal process) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; and
  - You have filed a request for an expedited internal appeal; or
- You exhaust the internal appeal process (level one and level two), if:
  - You have a medical condition where the timeframe for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

- It concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

As soon as Aetna receives your request for an expedited external review, Aetna will determine whether the request meets the reviewability requirements for standard external review and immediately notify you of its determination.

If your request for an expedited external review is approved, Aetna will assign an ERO. The ERO will make a decision as quickly as your medical condition or circumstances require, and within 72 hours after the ERO receives your request for the expedited review. If the ERO gives you its decision orally, the ERO must follow up with written confirmation to you, Aetna and the Plan within 48 hours of making the decision.

Claim Fiduciary

Claim decisions are made by the Claim Fiduciary in accordance with the provisions of the Plan. The Claim Fiduciary has complete authority to review denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically **necessary**. In exercising its fiduciary responsibility, the Claim Fiduciary has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Interpret the provisions of the Plan when a question arises.

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

Aetna is the Claim Fiduciary for the Plan, and has discretionary authority to review all denied claims for benefits under the Plan.

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

- Summary Plan Descriptions;
- Summary of material modifications; and
- Summary annual reports.

Recovery of Overpayment

If Aetna makes a benefit payment over the amount that you are entitled to under this Plan, Aetna has the right to:

- Require that the overpayment be returned on request; or
- Reduce any future benefit payment by the amount of the overpayment.

This right does not affect any other right of overpayment recovery Aetna may have.

Legal Action

No legal action can be brought to recover a benefit after three (3) years from the deadline for filing claims.

Subrogation and Right of Recovery

If you or your covered dependent receives benefits as the result of an illness or injury caused by another party, the Plan has the right to be reimbursed for those benefits from any settlement or payment you receive from the person who caused the illness or injury.

The provisions of this section apply to:

- All current or former Plan participants; and
- The parents, guardian or other representative of a dependent child who incurs claims and is or has been covered by the Plan.

The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. No adult covered person hereunder may assign any rights that he or she may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

Definition of "You"

As used in this section, "you" or "your" includes anyone on whose behalf the Plan pays benefits.

The Plan's right of subrogation or reimbursement, as set forth below, extends to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims, including (but not limited to):

- Liability coverage;
- Uninsured motorist coverage;
- Underinsured motorist coverage;

- Personal umbrella coverage;
- Medical payments coverage;
- Workers compensation coverage;
- No fault automobile coverage; or
- Any first party insurance coverage.

A Note About No-Fault

Your health Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

When You Accept Plan Benefits

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider), you agree to the following rules:

- ***Constructive trust:*** If you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan.
- ***Lien Rights:*** The Plan will automatically have a lien, to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition, upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including (but not limited to) you, your representative or agent, and/or any other source possessing funds representing the amount of benefits paid by the Plan.

- ***Assignment:*** In order to secure the Plan's recovery rights, you will assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.
- ***First-Priority Claim:*** The Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.
- ***Cooperation:*** You will cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents shall provide all information requested by the Plan, the Claim Administrator or its representative including (but not limited to) completing and submitting:
  - any applications or other forms or statements as the Plan may reasonably request; and
  - all documents related to or filed in person injury litigation.

  Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the termination of your health benefits or the institution of court proceedings against you.

  You shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan. If you fail to cooperate with the Plan in its efforts to recover such amounts or do anything to hinder or prevent such a recovery, you will cease to be entitled to any further Plan benefits. The Plan will also have the right to withhold or offset future benefit payments up to the amount of any settlement, judgment, or recovery you obtain, regardless of whether the settlement, judgment or recovery is designated to cover future medical benefits or expenses.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include (but are not limited to) insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*,, to share your personal health information in exercising its subrogation and reimbursement rights.

- ***Jurisdiction***: Any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting benefits from the Plan, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of:

- Whether any liability for payment is admitted; and
- Whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses.

The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Interpretation

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

Complaints

The Plan has procedures for you to follow if you are dissatisfied with the service you receive from the Plan or you want to complain about an in-network provider. To make a complaint about an operational issue or the quality of care you've received, you must write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant. Aetna will review the information and give you a written decision within 30 calendar days of the receipt of the complaint, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will tell you what you need to do to seek an additional review.

Recovery of Overpayment

If Aetna makes a benefit payment over the amount that you are entitled to under this Plan, Aetna has the right to:

- Require that the overpayment be returned on request; or
- Reduce any future benefit payment by the amount of the overpayment.

This right does not affect any other right of overpayment recovery Aetna may have.

Legal Action

No legal action can be brought to recover a benefit after three (3) years from the deadline for filing claims.

Administrative Information

This section includes information about the administration of the Plan described in this Summary Plan Description, as well as information required of all Summary Plan Descriptions by the Employee Retirement Income Security Act of 1974 (ERISA). While you may not need this information for your day-to-day participation, it is information you may find important from time to time.

Plan Information

- **Plan Name: Carilion Clinic Medical Plan**
- **Employer Identification Number (EIN):** 54-1190771
- **Plan Number:** 544
- **Plan Sponsor:**
  Carilion Clinic
  1212 3rd Street, SW
  Roanoke, VA 24016
- **Type of Plan**: Self-funded welfare plan
- **Plan Year**: January 1 – December 31
- **Plan Administrator**:
  Director of Benefits
  Carilion Clinic
  1212 Third Street
  Roanoke, VA 24016
  Phone: 800-599-2537
- **Agent of Service for Legal Process**:
  Office of General Counsel
  Carilion Clinic
  213 Jefferson Street, Suite 1600
  P.O. Box 40032
  Roanoke, VA 40032
  Phone: 540-224-5062

Plan Documents

The official Plan documents and agreements that govern the plans are summarized in the Summary Plan Description for the Plan (this book). Copies of those documents, as well as the latest annual reports of Plan operations and Plan descriptions as filed with the Internal Revenue Service and the U.S. Department of Labor, are available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may get a copy of these documents by written request to the Plan Administrator, for a nominal charge.

Future of the Plan

Although the Company expects to continue the Plan described in this book indefinitely, it necessarily reserves the right to discontinue the Plan and to implement any changes to it at any time, and for any reason, at the sole determination of the Company.

The management group of the Company may amend, modify, revoke or terminate the Plan at any time, as it may determine in its sole discretion.

The Company's decision to terminate or end the Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Service or the Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A Plan change may transfer Plan assets and debts to another plan or split the Plan into two or more parts. If the Company does change or terminate the Plan, it may decide to set up a different plan providing similar or different benefits.

If the Plan is terminated, both active and retired employees will not have the right to any other benefits from the terminated Plan, other than for those claims incurred prior to the date of termination or as provided by the individual contracts. In addition, if the Plan is amended, all covered persons – active, retired or beneficiaries – may be subject to altered coverage and benefits.

The amount and form of any final benefit you receive will depend on the provisions of any Plan document or agreement affecting the plans and decisions by the Company. After all benefits have been paid and other requirements of the law have been met, remaining Plan assets will be turned over to the Company.

Your ERISA Rights

As a covered person (participant) of the Plan described in this Summary Plan Description, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- Receive information about their Plan benefits.
- Examine, without charge, at the Plan Administrator's office, and at other specified worksites, all Plan documents – including pertinent insurance contracts, trust agreements, collective bargaining agreements, annual reports and other documents filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements, copies of the latest annual report and updated

Summary Plan Description, by writing to the Plan Administrator. The Plan Administrator may charge a reasonable fee for copies.

- Receive a summary annual report of the Plan's financial activities; the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Right to Continued Coverage – COBRA

You have the right to continue medical coverage for yourself and your covered dependents if there is a loss of coverage under the Plan as a result of a "COBRA event." See the section titled Continuing Plan Coverage Under COBRA and the documents governing those plans for rules governing your COBRA continuation rights.

You should be provided with a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA coverage and when your COBRA coverage ends, if you request it before losing coverage, or if you request it within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) for your new coverage.

Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why it was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules; see Claims and Appeals for details.

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

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

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

Assistance with Your Questions

If you have questions about the Plan described in this book, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

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

Notice of Privacy Practices

This Notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Who Will Follow this Notice?

The **Carilion Clinic Medical Plan.** It's important to note that these rules apply to the Plan, not Carilion Clinic ("Carilion") as an employer or provider. Different policies may apply to other Carilion programs or to data unrelated to the Plan.

The Plan may disclose your health information without your written authorization to Carilion for plan administration purposes. Carilion may need your health information to administer benefits under the Plan. Carilion agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law.

Here's how additional information may be shared between the Plan and Carilion, as allowed under the HIPAA rules:

- The Plan may disclose "summary health information" to Carilion, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan may disclose to Carilion information on whether an individual is participating in the Plan or has enrolled or disenrolled in an option offered by the Plan.

In addition, you should know that Carilion cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Carilion from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Our Responsibilities:

The Plan is required by law and is committed to:

- Maintain the privacy of your health information.
- Provide you with this Notice of our legal duties and privacy practices with respect to health information we collect and maintain about you.
- Abide by the terms of this Notice.

- Notify you if we are unable to agree to a requested restriction and, in most cases, allow you to request a review of our decision.
- Notify you if a breach of unsecured health information has occurred that involved your information.
- Not sell your health information without your written authorization.

Your Health Information Rights:

You have the following rights with respect to your health information:

- You may inspect and get a copy of your health information. This may include enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial. Your request to inspect or obtain copies of your health information must be made in writing, to the Plan Administrator. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:
  - The access or copies you requested
  - A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
  - A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

  You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

- If you feel that the health information we have about you is incorrect or incomplete, you may ask us to **amend the information**. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your

request must be made in writing and include the reason for your request. We may deny your request if you ask us to amend information that was not created by us. We may also deny your request to amend information if we believe the information is accurate and complete.

- You may **request a restriction or limitation** on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree to your request. Your request for restrictions must be made in writing and include the following information:(1) what information you want to limit; (2) how you want us to limit the information; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- You may **request an accounting of certain disclosures** we have made of health information about you. The accounting will not include disclosures made for purposes of treatment, payment or health care operations or made upon your written authorization. Other exceptions include, but are not limited to, disclosures for national security and intelligence and disclosures to law enforcement officials or correctional institutions. Your request must be in writing and state a time period for the accounting that may not be longer than six years and may not include dates before July 1, 2011. The first list you request within a 12-month period will be free.
- You may **request to receive communications of your health information by alternative means,** at alternative locations or in a confidential manner. For example, you may ask that we contact you only at work or by mail. We will accommodate all reasonable requests.
- You may **request a paper copy of this Notice** even if you have agreed to receive the Notice electronically. You may obtain a copy of this Notice through inside Carilion, our intranet.

Permitted Uses and Disclosures Which Do Not Require Your Authorization:

The following is a description of the types of uses and disclosures of your health information that we are permitted or required to make without your authorization:

- We will use or disclose your health information for **treatment**, which means the provision, coordination or management of the healthcare services provided to you. For example, the Plan may share your health information with physicians who are treating you.

- We will use or disclose your health information for **payment** activities necessary for us to receive reimbursement for the services we provide to you. For example: the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- We will use or disclose your health information for **healthcare operations**, such as quality assessments, evaluating practitioner performance, cost management and general administrative activities. For example: the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.
- We may disclose health information relevant to your care or payment for your care to a **family member**, other relative, a close personal friend or any other person identified by you.
- We may contact you to provide information about health-related benefits and services that may be of interest to you.
- We may also disclose health information as permitted or required by law, such as in the following circumstances:
  - to **prevent a serious threat** to your health or safety or the health or safety of others;
  - for **workers compensation** or other similar programs, to the extent required by law;
  - to **health oversight agencies** in connection with audits, investigations, inspections, licensure surveys or complaint/compliment evaluations;
  - to **public health or legal authorities** charged with maintaining health records or preventing or controlling disease, injury or disability, or authorized by law to receive reports of abuse or neglect;
  - to the **Food and Drug Administration** (**FDA)** for the purpose of activities related to the quality, safety or effectiveness of FDA-regulated products, such as to enable product recalls, repairs or replacement;
  - to **organ procurement** organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue or organ donation or transplant. Organs will only be procured with written authorization;
  - to **coroners, medical examiners or funeral directors** as necessary to carry out their duties or to protect the health or safety of their staff;
  - in response to a **court order, subpoena, warrant, summons** or other lawful process;
  - to a **law enforcement official** when required or permitted by law;

- to authorized **federal officials** for intelligence, counterintelligence and other national security activities, and as necessary to provide protection to the President of the United States or other individuals;
- if you are a member of the **armed forces**, as required by military command authorities; or
- if you are an **inmate of a correctional institution**, to the institution or agents in connection with your health or the health and safety of other individuals.

Other uses and disclosures of medical information not described in this Notice will be made only with your written authorization. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of health information for marketing purposes where we receive financial remuneration from a third-party, and disclosures that constitute a sale of health information, require authorization. If you authorize a use or disclosure of health information, you may revoke your authorization in writing, at any time. However, please understand that we are unable to take back a disclosure we have already made with your prior authorization.

Revisions to this Notice:

We reserve the right to change our privacy practices at any time and to make the new practices effective for all protected health information we maintain. Should our privacy practices change, we will amend this Notice and post a copy of the revised Notice on inside Carilion, our intranet website. The Notice will include an effective date on the first page.

For More Information or to Report a Problem:

If you have questions about this Notice and would like additional information, you may contact Carilion's Privacy Officer at 540-981-7000. If you believe your privacy rights have been violated, you may file a complaint with Carilion's Information Privacy Officer, Carilion's Information Security Officer, the Plan Administrator or Carilion's Compliance Department. You may also file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Regulatory Information

Women's Health Provisions

Federal law affects how certain health conditions are covered by the Plan. Your rights under these laws are described here.

The Newborns' and Mothers' Health Protection Act

Maternity hospital stays under the Plan will be covered for a minimum of 48 hours following a vaginal delivery, or 96 hours for a cesarean section delivery. These minimums are set by a federal law called The Newborns' and Mothers' Protection Act. However, the Plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician's assistant) discharges the mother or newborn earlier, after consulting with the mother.

Other provisions of this law:

- The level of benefits for any portion of the hospital stay that extends beyond 48 hours (or 96 hours) cannot be less favorable to the mother or newborn than the earlier portion of the stay.
- The Plan cannot require precertification for a stay of up to 48 or 96 hours, as described above.

The Women's Health and Cancer Rights Act

When a woman who is covered by the Plan decides to have reconstructive surgery after a medically necessary mastectomy, the Women's Health and Cancer Rights Act requires the Plan to cover these procedures:

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

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

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

Mental Health Parity and Addiction Equity Act of 2008

Effective January 1, 2010, the Mental Health Parity and Addiction Equity Act of 2008 applies to the mental health and substance abuse services provided under the Plan. The act requires mental health and substance use disorder benefits to have parity with medical and surgical benefits. Treatment limitations (such as the number of visits or days of coverage) and financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket expenses) that apply to mental health and substance abuse benefits must be no more restrictive than the most frequent or common medical and surgical limitations and requirements. The act also mandates parity for out-of-network coverage. Plans that cover out-of-network medical or surgical treatments must provide comparable coverage for out-of-network mental health and substance abuse benefits.

Genetic Information Nondiscrimination Act of 2008 (GINA)

Effective January 1, 2010, GINA prohibits health coverage and employment discrimination against a Plan participant based on his or her genetic information. Genetic information generally includes family medical history and information about an individual's and his or her family members' genetic tests and genetic services.

Under GINA, group health plans and health insurers providing group health plan coverage cannot use genetic information with respect to eligibility, premiums or contribution amounts. They also cannot request, require or purchase genetic information prior to a person's enrollment in a health care plan or request or require genetic testing of an individual for underwriting purposes. The availability of genetic testing and the results of any genetic testing you undergo will be treated as confidential, as required by GINA and the Health Insurance Portability and Accountability Act of 1996.

Glossary

The Glossary defines the words and phrases in **bold type** that appear throughout the text of this book.

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

Behavioral Health Provider
A licensed organization or professional providing diagnostic, therapeutic or psychological services for the treatment of mental health and substance abuse. Behavioral health providers include hospitals, residential treatment facilities, psychiatric physicians, psychologists and social workers.

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

Coinsurance
The sharing of covered expenses by the Plan and the covered person. The percentage of covered expenses paid by the Plan is the Plan's coinsurance. The percentage of covered expenses that you pay is your coinsurance. The Summary of Benefits shows you the coinsurance that you pay and what the plan pays for covered expenses.

Companion
This is a person who needs to be with an **NME patient** to enable him or her:

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

Copay/Copayment
This is a fee that you pay at the time you receive a covered service or prescription drug.

Custodial Care
This means services and supplies, including **room and board** and other institutional care, provided to help you in the activities of daily life. You do not have to be disabled. Such services and supplies are custodial care no matter who prescribes, recommends or performs them.

Deductible
This is the amount of covered expenses that a Plan participant must pay each calendar year before the Plan begins paying benefits.

Dentist
This means a legally qualified dentist or a **physician** licensed to do the dental work he or she performs.

Detox/Detoxification
This is care mainly to overcome the aftereffects of a specific episode of drinking or substance abuse.

Directory
This is a listing of in-network providers in the service area covered under the Plan. A current list of in-network providers may be obtained from Member Services and is also available through Aetna's online provider directory, DocFind at **www.aetna.com**.

Durable Medical Equipment
This is equipment – and the accessories needed to operate it – that is:

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

The Plan does not allow for more than one item of equipment for the same or similar purpose. Durable medical 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.

Effective Treatment of Alcohol or Substance Abuse
This means a program of alcohol or substance abuse therapy that is prescribed and supervised by a **behavioral health provider** and either:

- Has a follow-up therapy program directed by a physician on at least a monthly basis; or
- Includes meetings at least once a month with organizations devoted to the treatment of alcohol or substance abuse.

Note: Maintenance care (providing an alcohol- and/or drug-free environment) and **detoxification** are not considered "effective treatment."

Effective Treatment of a Mental Disorder
This is a program that:

- Includes a written treatment plan that is prescribed and supervised by a behavioral health provider;
- Includes follow-up treatment; and

- Is for a disorder that can be changed for the better.

Emergency Admission
This means a hospital admission when the physician admits you to the **hospital** right after the sudden and, at that time, unexpected onset of a change in your physical or mental condition:

- That requires confinement right away as a full-time inpatient; and
- For which, if immediate inpatient care were not given, could (as determined by Aetna) reasonably be expected to result in:
  - Placing your health in serious jeopardy; or
  - Serious impairment to bodily function; or
  - Serious dysfunction of a body part or organ; or
  - Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency Care
This means the treatment given to you in a hospital's emergency room to evaluate and treat medical conditions of recent onset and severity – including (but not limited to) severe pain – that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that your condition, sickness 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
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency Condition
This means a recent and severe medical condition – including (but not limited to) severe pain – that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that your condition, sickness 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
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Experimental or Investigational
A drug, device, procedure or care is considered experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- It does not have the approval required for marketing by the U.S. Food and Drug Administration; or
- A nationally recognized medical or dental society or regulatory agency has determined, in writing, that it is experimental, 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 U.S. Department of Health and Human Services; or
- The written protocol(s) or written informed consent used by the treating facility – or another facility studying the same drug, device, treatment or procedure – states that it is experimental, investigational or for research purposes.

Where Can I Find More Information?

Examples of how this evidence is applied to specific treatments and conditions, called Clinical Policy Bulletins, can be found on Aetna's website.

Formulary
A medication formulary is a list of **prescription drugs** that have been evaluated and selected for their therapeutic equivalency and efficacy. The listing includes both **brand-name drugs** and **generic drugs** and may be reviewed and changed from time to time.

Generic Drug
A generic drug is a prescription drug that is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home Health Care Agency
This is an agency that:

- Provides mainly skilled nursing and other therapeutic services; and
- Is associated with a professional group (of at least one physician and one **RN)** that makes policy; and
- Has full-time supervision by a physician or an RN; and
- Keeps complete medical records for each patient; and
- Has an administrator; and
- Meets licensing standards.

Home Health Care Plan
This is a plan that provides for care and treatment in your home. It must be:

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

Hospice Care
This is care provided to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency
This is an agency or organization that:

- 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; and
  - Medical social services; and
  - Psychological and dietary counseling;
- Provides, or arranges for, other services that include:
  - Physician services; and
  - Physical and occupational therapy; and
  - Part-time home health aide services that consist mainly 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; and
  - One RN; 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, including 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 for each patient;

- Uses volunteers trained in providing services for non-medical needs; and
- Has a full-time administrator.

Hospice Care Program
This is a written plan of **hospice care** that:

- Is established by and reviewed from time to time by your attending physician and appropriate hospice care agency personnel;
- Is designed to provide palliative (pain relief) and supportive care to terminally ill people and supportive care to their families; and
- Includes an assessment of your medical and social needs, and a description of the care to be given to meet those needs.

Hospital
This is a place that:

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

Infertile or Infertility
A person is considered infertile if he or she is unable to conceive or produce conception after one year (6 months if the female partner is over age 35) of frequent, unprotected heterosexual sexual intercourse.

In-Network Care
This is a health care service or supply furnished by:

- An **in-network provider**; or
- A health care provider who is not an in-network provider when there is an emergency condition and travel to a provider in the network is not possible.

In-Network Provider
This is a health care provider who has contracted to furnish services or supplies for a **negotiated charge**, but only if the provider is, with Aetna's consent, included in the directory as a preferred care provider for:

- The service or supply involved; and
- The class of employees to which you belong.

LPN
This means a licensed practical nurse.

Mental Disorder
This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis. Treatment for mental disorders is usually provided by or under the direction of a behavioral health provider such as a psychiatrist, psychologist or psychiatric social worker. Mental disorders include (but are not limited to):

- Alcohol and substance abuse
- Schizophrenia
- Bipolar disorder
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

Morbid Obesity
This means:

- Your body mass index (BMI) exceeds 40; or
- Your BMI exceeds 35 and you have one of the following conditions:
  - Coronary heart disease; or
  - Type 2 diabetes mellitus; or
  - Clinically significant obstructive sleep apnea; or
  - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic, despite optimal medical management).

Body mass index (BMI) is a marker that is used to assess the degree of obesity. To calculate your BMI:

- Multiply your weight in pounds by 703.
- Divide the result by your height in inches.
- Divide that result by your height in inches again.

NME Patient
This is a person who:

- Needs any of the National Medical Excellence (NME) program procedure and treatment types covered by the Plan; and
- Contacts Aetna and is approved by Aetna as an NME patient; and
- Agrees to have the procedure or treatment performed in a hospital that Aetna determines is the most appropriate facility.

Necessary/Medically Necessary

Health care services and supplies that a **physician**, other health care provider or **dentist**, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an **illness**, **injury** or disease. The service or supply must be:

- Provided in accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration;
- Considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, physician, dentist or other health care provider; and
- Not more costly than an alternative service or sequence of services that would be 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 or dental practice” means standards that are:

- Based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community; or
- Otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

Negotiated Charge
This is the maximum fee an in-network provider has agreed to charge for any service or supply for the purpose of benefits under this Plan.

Non-Occupational Disease
A non-occupational disease is a disease that does not:

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

A disease will be considered non-occupational regardless of its cause if proof is provided that you:

- Are covered under any type of Workers’ Compensation law; and
- Are not covered for that disease under such law.

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

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

Orthodontic Treatment
This is any medical or dental service or supply given to prevent, diagnose or correct a misalignment of:

- The teeth;
- The bite; or
- 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.

Out-of-Network Care
This is a health care service or supply provided by an **out-of-network provider** if, as determined by Aetna:

- The service or supply could have been provided by an in-network provider; and
- The provider does not belong to one or more of the provider categories in the **directory**.

Out-of-Network Provider
This is a health care provider who does not belong to Aetna's network and has not contracted with Aetna to furnish services or supplies at a negotiated charge**.**

Out-of-Pocket Maximum
The out-of-pocket maximum is the maximum that you must pay out of pocket for covered expenses each calendar year.

Partial Confinement Treatment
A medically supervised day, evening and/or night treatment program for mental health or substance abuse disorders. Care is coordinated by a multidisciplinary treatment team. Services are provided on an outpatient basis for at least four hours per day and are available at least three days per week. The services are of the same intensity and level as inpatient services for the treatment of behavioral health disorders.

Pharmacy
An establishment where prescription drugs are legally dispensed.

Physician (Doctor)
This means a legally qualified physician. The term "doctor" is also used throughout this book, and has the same meaning as "physician."

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

Prescription
A **prescriber**'s order for a prescription drug. If it is an oral order (such as a phoned-in prescription), it must be put in writing promptly by the pharmacy.

Prescription Drugs
Any of the following:

- A drug, biological or compounded prescription that, by federal law, may be dispensed only by prescription and that is required to be labeled "Caution: Federal law prohibits dispensing without prescription."
- An injectable contraceptive drug prescribed to be administered by a paid health care professional.
- An injectable drug prescribed to be self-administered or administered by another person except someone who is acting within his or her capacity as a paid health care professional. Covered injectable drugs include insulin.
- Disposable needles and syringes purchased to administer a covered injectable prescription drug.
- Disposable diabetic supplies.

Psychiatric Hospital
An institution that meets ***all*** of the following criteria:

- Mainly provides a program for the diagnosis, evaluation and treatment of mental disorders or alcohol or substance abuse.
- Is not mainly a school or custodial, recreational or training institution.
- Provides infirmary-level medical services.
- Provides, or arranges with a hospital in the area to provide, any other medical service that may be needed.
- Is supervised full-time by a psychiatric physician who is responsible for patient care.
- 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 RN.
- Prepares and maintains a written plan of treatment for each patient. The plan must be supervised by a psychiatric physician.
- Charges for its services.

- Meets licensing standards.

RN
This means a registered nurse.

Recognized Charge
The **recognized charge** is the lower of:

- The provider's usual charge to provide that service or supply; or
- The charge Aetna determines to be appropriate, based on factors such as:
  - The cost of supplying the same or a similar service or supply; and
  - The way charges for the service or supply are made, billed or coded.

  For non-facility charges: Aetna uses the 80th percentile of charges as reported in a database of charges that Aetna receives from a third party. Aetna may contribute information to that third party that is used in assembling the database.

  For facility charges: Aetna uses the charge Aetna determines to be the usual charge level for the service in the geographic area where the service is furnished.

Aetna may reduce the recognized charge to address the appropriate billing of services, taking into account factors 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;
- Whether follow-up care is included;
- Whether there are any other factors that modify or make the service unique; and
- Whether any services are part of or incidental to the primary service provided if the charge includes more than one claim line.

Aetna's reimbursement policies are based on:

- Aetna's review of policies developed for Medicare;
- Generally accepted standards of medical and dental practice; 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.

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

Residential Treatment Center
This is an institution that:

- Specializes in the treatment of psychological and social disturbances that are the result of mental health or substance abuse conditions;
- Provides a sub-acute, structured, psychotherapeutic treatment program under the supervision of physicians;
- Provides 24-hour care, in which the patient lives in an open setting; and
- Is licensed as a residential treatment center in accordance with the laws of the appropriate legally authorized agency.

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

Semi-Private Room Rate
This is the **room and board charge** that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility
This is an institution that:

- Is licensed or approved under state or local law;
- 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.
- Is primarily engaged in providing skilled nursing care and related services for residents who need:
  - Medical or nursing care; or
  - Rehabilitation services because of injury, illness or disability;
- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

  - Professional nursing care by an RN, or by an LPN directed by a full-time RN; 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 RN;
- Is supervised full-time by a physician or RN;
- Keeps a complete medical record for each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for people who are mentally retarded, or for custodial or educational care;
- Is not mainly a place for the care and treatment of alcoholism, substance abuse or mental disorders, and
- Charges for its services.

A skilled nursing facility may be a rehabilitation hospital or a portion of a hospital designated for skilled or rehabilitation services.

Specialist
A specialist is a physician who practices in any generally accepted medical or surgical sub-specialty, and provides care that is not considered routine medical care.

Surgery Center
This is a freestanding ambulatory surgical facility that:

- 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 whom is on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery that requires 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 to dentists who perform oral surgery.
- Has at least two operating rooms and one recovery room.
- Provides or arranges with a medical facility in the area for diagnostic X-ray and laboratory 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 RN.

- Is equipped and has staff trained to handle medical emergencies.
- Must have a physician trained in CPR, a defibrillator, a tracheotomy set and a blood volume expander.
- Has a written agreement with an area hospital for the 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 that includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record for each patient.

Terminally Ill
This is a medical prognosis of 12 months or fewer to live.

Treatment Facility (for alcohol or substance abuse)
This is an institution that:

- Mainly provides a program for diagnosis, evaluation and **effective treatment of alcohol or substance abuse**.
- Charges for its services.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a physician.
- Provides, on the premises, 24 hours a day:
  - Detoxification services needed for its effective treatment program.
  - Infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical services that may be required.
  - Supervision by a staff of physicians.
  - Skilled nursing care by licensed nurses who are directed by a full-time RN.

Treatment Facility (for mental disorders)
This is an institution that:

- Mainly provides a program for the diagnosis, evaluation and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.

- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time RN.
- 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.
- Charges for its services.
- Meets licensing standards.

Urgent Admission
An urgent admission is one in which the physician admits you to the hospital because of:

- The onset of, or change in, a disease; or
- The diagnosis of a disease; or
- An injury caused by an accident;

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

Urgent Care Provider
This is a freestanding medical facility that:

- Provides unscheduled medical services to treat an urgent condition if your physician is not reasonably available;
- Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours;
- Charges for services;
- Is licensed and certified as required by state or federal law or regulation;
- Keeps a medical record for each patient;
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or run the facility;
- Is run by a staff of physicians, with one physician on call at all times; and
- Has a full-time administrator who is a physician.

An urgent care provider may also be a physician's office if it has contracted with Aetna to provide urgent care and is, with Aetna's consent, included in its provider directory as an in-network urgent care provider.

A hospital emergency room or outpatient department is not considered to be an urgent care provider.

Urgent Condition
This is a sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious health problems;
- Includes a condition that could cause you severe pain that cannot be managed without urgent care or treatment;
- Does not require the level of care provided in a hospital emergency room; and
- Requires immediate outpatient medical care that can't be postponed until your physician becomes reasonably available.

Walk-In Clinic
A free-standing health care facility that:

- Treats unscheduled and/or non-emergency illnesses and injuries; and
- Administers certain immunizations.

A walk-in clinic must:

- Provide unscheduled and/or non-emergency medical services;
- Make charges for the services provided;
- Be licensed and certified as required by any state or federal law or regulation;
- Be staffed by independent practitioners, such as Nurse Practitioners, licensed in the state where the clinic is located;
- Keep a medical record on each patient;
- Provide an ongoing quality assurance program;
- Have at least one physician on call at all times;
- Have a physician who sets protocol for clinical policies, guidelines and decisions; and
- Not be the emergency room or outpatient department of a hospital.