

City of Fort Worth Health Benefit Plan

Summary Plan Description

Aetna Group Number: 889000

Aetna Traditional Plan

*For Retirees, Survivors and Dependents who are eligible for
Medicare Part A or Medicare Part A and Part B*

Effective: January 1, 2005
Restated: October 1, 2007

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Introduction

The medical plan described in this booklet is an important employee benefit designed to help keep good health care affordable for you and your family. It provides benefits for preventive care and access to special programs that focus on helping you stay healthy, plus the coverage you need when an illness or injury strikes.

This Benefits Summary describes your benefits as well as your rights and responsibilities when accessing care through the City of Fort Worth Health Benefit Plan. To take full advantage of all that your plan offers, it's important to know how the plan works – and how to make it work for you. Reading this booklet is a great place to start.

In This Booklet

This Summary Plan Description describes the City of Fort Worth Aetna Traditional Indemnity Medical Plan option effective January 1, 2005. It describes the main features of the plan – who is eligible for coverage, what is covered and not covered, what to do when you need care, how the plan pays benefits, and when coverage ends.

To understand what certain important words in **bold type** mean, turn to the *Glossary* at the back of the booklet.

The words “we,” “us,” and “our” in this document refer to the City of Fort Worth. The words “you” and “your” refer to people who are covered persons as defined in the *Eligibility* section of this booklet. The term Plan Administrator refers to the City of Fort Worth.

Your Contribution to the Benefit Costs

The Plan may require you to contribute to the cost of coverage. A copy of the rates is available in the Benefits Division of the Human Resources office. Contact your City of Fort Worth Benefits Representative for information about any part of this cost you may be responsible for paying.

Important Notices

The plan described in this booklet is administered by Aetna Life Insurance Company of Hartford, Connecticut (referred to as “Aetna”). The benefits are effective only while you are covered under the plan.

*This summary contains information about the Traditional Plan. **If you have coverage under the Basic, Basic Plus or Select Plan, you should read the appropriate Summary Plan Description for that plan.***

Your Health Care Coverage

The plan covers medically **necessary** health care expenses as well as certain preventive care expenses that are incurred while your coverage is in effect. An expense is incurred on the day you receive a health care service or supply.

The plan does not pay benefits for expenses incurred before your coverage starts or after it ends.

When a single charge is made for a series of services, each service will be assigned a pro rata (evenly divided) share of the expense. Aetna will determine the pro rata share. Only the pro rata share of the expense will be considered as incurred on the date of the health care service.

Outcome of Covered Services and Supplies

Aetna is not responsible for and makes no guarantees concerning the outcome of the covered services and supplies you receive.

Benefits Assistance and Resources

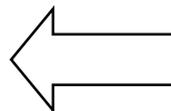
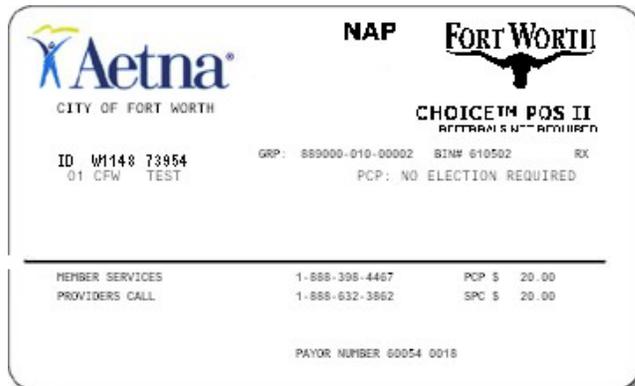
When you need help, answers or information, here are some resources available to you.

	Telephone	Web Site
Aetna Member Services) <i>Claim status, covered services and benefit levels, network providers, replacement ID cards, access to special programs</i>		
• Active Employees	888-398-4467	Aetna Navigator at www.aetna.com
• Retirees	888-397-4537	
• COBRA	800-429-9526	
• Aetna On-site Representative	817-392-7780	
City of Fort Worth HR/Employee Benefits <i>Address and family status changes</i>		
City of Fort Worth Benefits Office Lower Level 1000 Throckmorton Street Fort Worth, TX 76102	817-392-8577	---
Aetna Claims Submission Address		
Aetna P.O. Box 14586 Lexington, KY 40512-4586		

ID Cards

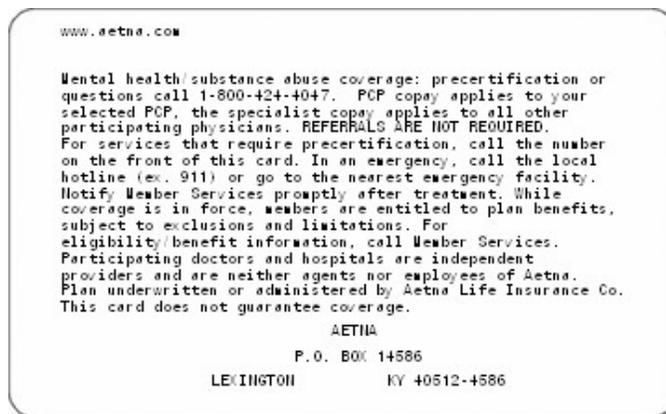
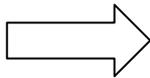
When you enroll in the plan, you receive an ID card. If you cover your spouse, you will receive an additional card for your spouse. The ID card shows:

- The name and identification number of each covered family member
- The Aetna Member Services telephone number and address



Front of ID Card

Back of ID Card



Aetna Navigator™

Aetna Navigator is Aetna’s self-service website that you can visit for health and benefits information, self-service features, interactive tools and more. After a simple registration process, you can use Aetna Navigator to verify eligibility information, check benefits and claim status, and as your gateway to:

- **DocFind®**, Aetna’s online provider directory that gives you the most recent information on Aetna’s network doctors, hospitals and other providers. You can learn about each provider’s credentials and practice, including education, board certification, languages spoken, office location and hours, and parking and handicapped access.

In DocFind, choose “Aetna Choice POS II” from the list of Aetna Open Access plans to find network providers in your area.

- **Intelihealth®**, Aetna’s health website that you can search for topics from specific health conditions and their treatment to developments in disease prevention, wellness and fitness.
- **Healthwise® Knowledgebase**, an innovative decision-support tool that provides information on thousands of health-related topics to help you make better decisions about health care and treatment options.
- **Health History Report**, an easy-to-understand, printable summary of doctor visits, tests, treatments and other health-related activity.

Visit Aetna Navigator at www.aetna.com.

Eligibility

These are eligibility rules for retired employees and their spouses and dependents who have permanent residency within the United States for participation in the City's group health benefits program. These rules may be amended from time to time. Please contact the Human Resources Department for the latest revision of this information.

Retirees

Specific Rule for Enrollment in the Traditional Plan

A City of Fort Worth retiree and eligible dependent(s) or eligible surviving dependent(s) of a retiree ***must be enrolled*** in Medicare Part A or Part A and Part B*.

An eligible Retiree is one:

1. Who has retired and is receiving pension disbursements from the City of Fort Worth Retirement System; or
2. Who has vested, but who has not elected to begin distribution.

NOTE: If an eligible retiree fails to enroll and add eligible dependents within sixty (60) days of loss of coverage as an active employee, the retiree and eligible dependents will not be eligible to enroll in the City's plan at any time in the future.

* A covered retiree's election not to enroll in Part B of Medicare has the potential to expose the covered retiree to significant expense at the time of claim. The same is true of the covered Medicare-eligible dependents of the retiree.

An eligible retiree enrolled only in Medicare Part B must enroll in one of the City's Choice POS II Plans. They are Basic, Basic Plus and Select. The retiree cannot enroll in the Traditional Choice Plan.

Dependents of Retirees and Vested Employees

The following rules determine dependent eligibility for the City's health plan. A dependent is only eligible for the Traditional Plan if he or she satisfies these rules *and* is also enrolled in Medicare Part A only or Medicare Part A and Part B. If a dependent satisfies the following rules but is not covered by Medicare, the dependent would be eligible for coverage under one of the City's POS plans.

1. To be eligible to enroll as a dependent, a person must be:
 - a. either the spouse of a covered retired, or

b. the surviving spouse of a covered retired or vested employee at the time of the employee's retirement or at the time of the employee's election of coverage as a vested employee.

c. a dependent unmarried natural child, foster child, stepchild, legally adopted child or child under the covered retired or vested employee's legal guardianship or custodianship, residing with the covered retired or vested employee or with the covered retired or vested employee's present or former spouse who is:

- under nineteen (19) years of age, or
- under twenty-three (23) years of age, primarily dependent on the covered retired or vested employee for financial support and attending a state accredited college, university, trade, or secondary school on a full time basis, which has, in writing, verified said attendance, or

d. a dependent unmarried natural child, foster child, stepchild, legally adopted child or child under the covered retired or vested employee's legal guardianship or custodianship, residing with the covered retired or vested employee or with the covered retired or vested employee's present or former spouse, who is nineteen (19) years of age or older but incapable of self-sustaining employment because of mental retardation or physical handicap commenced prior to age nineteen (19) (or commenced prior to age twenty-three (23) if such child was attending a recognized college or university, trade or secondary school on a full-time basis when such incapacity occurred) and primarily dependent upon the Enrollee for support and maintenance. Such dependent child must have been enrolled under the City's benefit plan either prior to attaining nineteen (19) years of age or twenty-three (23) years of age under the conditions of the previous sentence. The covered retired or vested employee shall give the City proof of such incapacity and dependency within thirty-one (31) days before the dependent child's attainment of the limiting age and from time to time thereafter as the City deems appropriate, or

e. the dependents of a retired employee who are entitled to receive survivor pension benefits through the City of Fort Worth and who were enrolled as dependents on the retired employee's plan at the time of the employee's death provided they enroll within sixty (60) days of the death of the covered retired employee, or

f. dependents who became covered prior to the date of the Member's retirement provided they are enrolled on or before the covered retiree's date of retirement except certain newborn children, or

- g. a newborn child of a covered retired employee, or a spouse of a covered retired employee, and/or of a covered retiree's covered unmarried dependent child that results from a pregnancy that existed at the time of the covered retired or vested employee's date of retirement shall be covered for an initial period of thirty-one (31) days from the date of birth, and shall continue to be so covered after that time only if, prior to the expiration of such thirty-one (31) day period, the covered retired or vested employee notifies the Human Resources Department with an application submitted for such newborn child.

Newborn children of a covered retired employee, of a covered retired employee's spouse, and/or of the retiree's covered unmarried dependent from a pregnancy that occurs after retirement, shall be covered for a period of thirty-one (31) days from the date of birth only.

Retired employees are required to make a contribution for the cost of their dependent's coverage as set forth by the City Council and as may be amended from time to time.

Survivors are required to make contribution for the cost of their coverage as set forth by the City Council and as may be amended from time to time.

Method of Payment

Retirees who participate in the cost of their own health coverage and who pay for eligible dependent coverage authorize deductions for the required participation through deductions from their monthly pension checks. Retirees whose monthly pension checks are insufficient to pay the premium must arrange a payment plan with the Human Resources Department to make supplemental payments to maintain the desired coverage. Arrangements are to be made for monthly payments in advance. In cases of extreme hardship, supplemental payment monthly in advance may be granted. If a retired employee falls into arrears in required contributions, he/she will be notified and will be allowed to correct the arrearage. If the arrearage continues 45 days after notification, coverage for all dependents will be terminated and the retiree's health benefits reduced to the "no cost participation required" level of benefits if the retiree is eligible for such a plan or terminated if any payment by the retiree is required to keep coverage in effect.

Important Plan Terms

Depending upon your years of service with the City, you may share in the cost of your care by making premium contributions. In addition, you may also be required to pay coinsurance.

The plan pays part of your covered expense and any amount paid by you is called coinsurance. The member's coinsurance percentage for the Traditional Plan is generally 10%. However, this 10% coinsurance may be reduced or even eliminated if Medicare has made a payment on your claim.

The plan puts a limit on the dollar amount you pay for covered expenses out of your own pocket – called the **coinsurance out-of-pocket maximum**. The coinsurance out-of-pocket maximum is shown in the *Summary of Benefits* that can be found later in this booklet. Once your share of covered expenses reaches the individual out-of-pocket maximum, the plan pays 100% of covered expenses for the rest of the plan year. Each January 1, you start over with a new coinsurance out-of-pocket maximum.

How the Plan Works for Medical Services Not Covered by Medicare

Your health plan is Aetna's Traditional Indemnity Plan. With this indemnity plan, you and your covered family members have the freedom to receive care from any licensed physician, hospital or other health care provider. There are no network providers for this plan.

When you visit a health care provider, remember to show your Aetna ID card. You may be required to pay for your care at the time you receive it or you may be billed later. Either way, once you have an itemized bill for your care, you must file a claim for reimbursement from the plan. The plan pays a certain percentage of your covered expenses (generally 90%) and you pay the rest.

The plan generally pays a benefit for covered expenses up to what Aetna considers the reasonable and customary amount for a given health service. A ***reasonable and customary charge*** is the provider's usual charge or the charge Aetna determines to be appropriate or most common for a given service or supply in a specific geographic area. A provider's fee for a given service may be more than the reasonable and customary amount, as determined by Aetna. In this case, the plan's benefit applies only to the part of the charge that is reasonable and customary. You must pay the difference. Any charges over the reasonable and customary charge do not count toward your coinsurance out-of-pocket limit.

The National Advantage™ Program

You may lower your out of pocket costs by visiting doctors or facilities that participate in Aetna's National Advantage Program (NAP) network. NAP doctors and facilities have agreed to accept negotiated rates for certain covered services. If you visit a NAP doctor or facility, you may receive a discount off billed charges.

When you visit a NAP provider, allow the provider to submit the claim. After your claim is processed at the discounted rate, you'll be billed for any applicable coinsurance or non-covered service.

Visit DocFind at www.aetna.com to find participating NAP doctors and facilities.

Summary of Benefits

The *Summary of Benefits* chart in this section shows the coinsurance, coinsurance out-of-pocket maximum, benefits and benefit limits for the major types of covered expenses.

The sections, *What the Plan Covers* and *What the Plan Does Not Cover* include more detail about specific services and supplies.

Summary of Benefits

Plan Features	Member Responsibility
Calendar Year Deductible	None
Coinsurance Out-of-Pocket Maximum	
• Individual	\$2,000
• Family	\$4,000
Lifetime Maximum	Unlimited

Covered Expense	Plan Pays
Physician Services	
• Office Visits	90%
• In-Hospital Physician Services	90%
• Other Physician Services	90%
Preventive Care Services	
• Routine Physical Exams Includes Immunizations <i>six visits first year of life; two visits 13 – 24 months of life; one visit per calendar year thereafter for children and adults</i>	90%
• Routine OB/GYN Exam <i>(one routine exam per calendar year; including Pap smear and related lab expenses)</i>	90%
• Routine Mammography <i>(one routine mammogram per calendar year for females age 40 and older)</i>	90%
• Routine Digital Rectal Exam (DRE) and Prostate Antigen Test (PSA) <i>(one per calendar year for males age 40 and over)</i>	90%
• Routine Vision Exam with Refraction Services <i>(one exam per 24 months)</i>	90%
Allergy Testing	90%
Allergy Injections	90%
Maternity	
• Prenatal and postnatal visits	90%

Summary of Benefits

Covered Expense	Plan Pays
Hospital Services	
• Inpatient Facility	100%
• Bariatric Surgery (precertified and approved by the City of Fort Worth)	100%
• Outpatient Facility	100%
• Emergency Room (physicians, surgery, anesthesia, lab and x-ray)	100%
• Non-Emergency Use of the Emergency Room	50%
Ambulance	90%
Diagnostic X-ray and Laboratory	
• Hospital	100%
• Independent Lab Facility	90%
Skilled Nursing/Convalescent Facility (up to 120 days per year)	100%
Home Health Care (up to 120 visits per year)	90%
Hospice Care (combined 360 days per year)	100%
Short-Term Rehabilitation (physical, occupational and speech therapy. Up to 60 visits per year)	90%
Chiropractic Care (up to 30 visits per year)	90%
Durable Medical Equipment	90%
Mental Health and Alcohol and Drug Abuse	
• Inpatient Care (up to 30 days per calendar year)	100%
• Outpatient Care (up to 60 visits per calendar year)	90%
Alcohol and Drug Abuse Lifetime Maximum	3 courses of treatment per lifetime

Summary of Benefits - Prescription Drugs

Plan Feature	Member Responsibility
Calendar Year Deductible	
• Individual	\$50
• Family	\$150

Covered Expense	Plan Pays
Retail Pharmacy (30-day supply)	
• Generic	100% after deductible and \$10 member co-pay
• Brand Formulary	100% after deductible and \$30 member co-pay
• Brand Non-Formulary	100% after deductible and \$50 member co-pay
Mail Order Pharmacy (90-day supply)	
• Generic	100% after deductible and \$25 co-pay
• Brand Formulary	100% after deductible and \$75 co-pay
• Brand Non-Formulary	100% after deductible and \$125 co-pay

What the Medical Plan Covers

While the *Summary of Benefits* charts outline the deductibles, coinsurance, out-of-pocket maximums, age, frequency and lifetime maximums for the major types of covered expenses, this section further describes the services and supplies covered under the medical plans. It also describes limits and exclusions that may apply to a specific type of expense.

Although a service may be listed as a covered benefit, it will not be covered unless it is medically **necessary** for the prevention, diagnosis or treatment of your illness or condition or considered covered preventive care as specifically outlined. Refer to the *Glossary* for a definition of “necessary.”

Physician Services

Routine Physical Exams

The plan covers charges made by a **physician** for a routine physical exam given to you, your spouse or your dependent child. Included as part of the exam are:

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

A physical exam for your dependent child must include at least:

- A review and written record of the patient’s complete medical history;
- A check of all body systems; and
- A review and discussion of exam results with the patient or with the parent or guardian.

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

The plan does *not* cover (as part of any routine physical exam):

- Services to the extent they are covered under any other part of this plan.
- Services covered to any extent under any other group plan sponsored by The City of Fort Worth.
- Services to diagnose or treat a suspected or identified injury or disease.
- Exams given while the person is confined in a hospital or other facility for medical care.
- Services not provided by a physician or under the direct supervision of a physician.
- Medicines, drugs, appliances, equipment or supplies.
- Psychiatric, psychological, personality, or emotional testing or exams.
- Any employment-related exams.
- Premarital exams.

Vision Exams for Refractive Services

The plan included benefits for one (1) complete refraction eye exam every 24 months performed by a qualified ophthalmologist or optometrist. There is no coverage for eyewear or contact lenses.

This plan provision does not cover charges for:

- Exams which do not include refraction (exams for diagnosis or treatment of a medical problem may be covered under another plan provision);
- Any service or supply provided while not covered under the plan;
- Any exams given while confined in the hospital or facility for medical care; or
- Any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or government law.
- Drugs or medicines;
- Any service or supply that does not meet professionally accepted standards.

Other Physician Services

The plan covers physician home and office visits for the treatment of illness or injury. Other physicians' services are also covered including those for:

- Inpatient physician visits;
- Second surgical opinions;
- Allergy testing and treatment;
- Radiation therapy and chemotherapy;
- Cardiac rehabilitation; and
- Pregnancy-related care.

Hospital Services

Inpatient Hospital Expenses

The plan covers charges made by a **hospital** for room and board and other hospital services and supplies for a person confined as an inpatient. Room and board charges are covered up to the hospital's **semi-private room rate**. (A semi-private room is one with two or more beds.)

Room and board charges include:

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

The plan also pays for other services and supplies provided during an inpatient stay, such as:

- Physician and surgeon services;
- Operating and recovery rooms;
- Intensive or special care facilities;
- Radiation therapy, physical therapy and occupational therapy;
- Oxygen and oxygen therapy;
- X-rays, lab tests and diagnostic services;
- Medication; and
- Social services planning.

Outpatient Hospital Expenses

The plan covers charges made by a **hospital** for hospital services and supplies provided to a person who is not confined as an inpatient. Charges include:

- Professional fees;
- Services and supplies furnished by the hospital on the day of a treatment, procedure or test;
- Services of an operating physician for surgery, related pre- and post-operative care, and administration of an anesthetic; and
- Services of any other physician for the administration of a general anesthetic.

Emergency Care

Emergency Room

The plan covers **emergency care** provided in a hospital emergency room while a person is not a full-time inpatient. The care must be for an **emergency condition**.

The plan benefits are reduced for non-emergency care provided in a hospital emergency room.

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

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

Ambulance

The plan covers charges for a professional ambulance to transport a person from the place where he/she is injured or becomes ill to the first hospital where treatment is given. When, in a medical emergency, the first hospital does not have the required services, transportation to another hospital is also covered.

Skilled Nursing / Convalescent Care

The plan covers charges made by a **skilled nursing facility** (convalescent facility) for the services and supplies listed below. These must be provided to a person while confined to recover from a disease or injury.

- Room and board, including charges for services (such as general nursing care) made in connection with room occupancy. Any charge for room and board in a private room that exceeds the hospital's semi-private room rate is *not* covered.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services provided by a skilled nursing facility. This does not include private or special nursing, physician services, drugs, biologicals, solutions, dressings, casts and other supplies.

The plan pays benefits for up to 120 days for skilled nursing services per calendar year.

Convalescent facility care does *not* include charges for treatment of:

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

Home Health Care

The plan covers home health care expenses when care is provided by a **home health care agency** as part of a **home health care plan**, and the care is provided to a covered person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by a R.N. or L.P.N., if a R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational and speech therapy.
- The following services, to the extent they would have been covered if the person had been confined to a hospital or convalescent facility:
 - Medical supplies;
 - Drugs and medicines prescribed by a physician; and
 - Lab services provided by or for a home health care agency.

The plan covers up to 120 home health care visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

The plan does *not* cover home health care charges for:

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

Hospice Care

The plan covers **hospice care** that is provided as part of a hospice care program for a person with a prognosis of six months or less to live. Hospice care coverage is described below.

Facility Expenses

The plan covers charges made by a hospice facility, hospital or convalescent facility on its own behalf for:

- Room and board, and other services and supplies provided to a person while a full-time inpatient for pain control and other acute and chronic symptom management. (The plan covers charges for room and board up to the facility's semi-private room rate.)
- Services and supplies provided on an outpatient basis.

Other Hospice Care Agency Expenses

The plan covers charges made by a hospice care agency for:

- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to 8 hours in any one day.
- Medical social services under a physician's direction. These include:
 - Assessment of the person's social, emotional and medical needs, and the home and family situation;
 - Identifying community resources available to the person; and
 - Helping the person make use of these resources.
 - Psychological and dietary counseling.
- Consultation or case management services provided by a physician.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These services consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a physician.

Charges made by a physician for consulting or case management services, and charges made by a physical or occupational therapist are also covered if:

- The provider is not an employee of a hospice care agency; and
- A hospice care agency is still responsible for the person's care.

Home Health Care Agency Expenses

As part of its **hospice care** coverage, the plan covers **home health care agency** expenses for:

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

The plan limits coverage for bereavement counseling and respite care to a maximum of 3 visits within 3 months. Respite care is care provided when the person's family or usual caretaker can't or won't care for the person.

The plan's hospice care benefit does *not* include coverage for:

- 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 person and include sitter or companion services for the person who is ill or other family members; transportation; housecleaning and home maintenance.

Short-Term Rehabilitation

The plan covers charges made by a hospital or licensed health care facility; a physician; or a licensed or certified physical, occupational or speech therapist for short-term rehabilitation on an outpatient basis.

Short-term rehabilitation is therapy expected to result in the improvement of a body function (including speech) which was lost or impaired because of:

- An injury,
- A disease, or
- Major congenital abnormalities such as cleft lip and cleft palate, cerebral palsy, hearing impairment, autism and developmental disabilities in children.

The plan covers physical, occupational or speech therapy provided to a person who is not confined as an inpatient in a hospital or other facility for medical care. Therapy will be expected to result in significant improvement of the person's condition within 60 days from the date therapy begins. The plan covers up to 60 visits per person per calendar year.

This benefit does *not* cover short-term rehabilitation when:

- Any therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning to prevent a medical problem from occurring or recurring;
- Services are received while a person is confined in a hospital or other medical facility for medical care;
- Rehabilitation services are covered under any other part of this plan or any plan sponsored by The City of Fort Worth.
- Services are provided by a physical, occupation or speech therapist who lives in the patient's home or is a family member of the patient or his/her spouse;
- Services are not performed by a physician or under his/her direct supervision;
- It is for special education, including lessons in sign language, to teach a person whose ability to speak has been lost or impaired, to function without that ability.
- Services are not provided in accordance with a specific treatment plan that details the treatment to be provided and the frequency and duration of treatment; provides for ongoing reviews; and is renewed only if therapy is still necessary.

Chiropractic Care (Spinal Manipulation)

The plan covers expenses for chiropractor care to treat any condition caused by or related to biomechanical or nerve conduction disorders of the spine. Benefits are paid for up to 30 visits per calendar year combined in- and out-of-network. This maximum does *not* apply to expenses incurred:

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

Family Planning

Voluntary Sterilization

The plan covers charges for a vasectomy or tubal ligation performed by a physician or hospital. The plan does *not* cover charges for the reversal of a sterilization procedure.

Pregnancy Coverage

The plan pays benefits for pregnancy-related expenses on the same basis as it would for an illness. For inpatient care of a mother and newborn child, benefits will be payable for a minimum of:

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

To be covered, expenses must be incurred while covered by the plan. Any pregnancy benefits payable by a previous group medical plan will be subtracted from benefits payable under this plan.

Infertility Coverage

The plan covers services to diagnose and treat an underlying medical condition which causes infertility when provided by or under the direction of a physician.

Mental Health and Substance Abuse Treatment

The plan covers expenses for inpatient and outpatient treatment of alcoholism or drug abuse, and mental disorders as explained below.

Hospital

If a person is a full-time inpatient in a hospital, the plan covers:

- Treatment for the medical complications of alcoholism or drug abuse. “Medical complications” include cirrhosis of the liver, delirium tremens or hepatitis.
- **Effective treatment of alcoholism or drug abuse.**
- Treatment of **mental disorders**.

Treatment Facility

If a person is a full-time inpatient in a treatment facility, the plan covers certain expenses for the **effective treatment** of alcoholism, drug abuse or mental disorders. These expenses are:

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

Outpatient Treatment

The plan also covers effective treatment of alcoholism, drug abuse or mental disorders on an outpatient basis.

Benefit Maximums

- For inpatient care, the plan covers up to 30 days per calendar year for mental health and substance abuse treatment.
- For substance abuse, the plan includes a lifetime maximum of 3 series of treatment per lifetime which includes rehabilitation, detoxification, residential care and partial confinement expenses.
- For outpatient care, the plan covers up to 60 visits per calendar year for mental health and substance abuse treatment.

Oral Surgery

The plan covers treatment of the mouth, jaws and teeth as follows:

- Surgery needed to:
 - Treat an accidental injury;
 - Remove cysts, tumors or other diseased tissues;
 - Alter the jaw, jaw joints or bite relationships to treat TMJ when appliance therapy cannot result in functional improvement.

This benefit does *not* cover charges:

- For surgery to remove teeth (whether or not routine);
- For periodontal treatment;
- 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
- Non-surgical treatment of infections or diseases;
- For dental cleaning, in-mouth scaling, planning or scraping;
- For myofunctional therapy (muscle training therapy to correct or control harmful habits).

Durable Medical Equipment

The plan covers durable medical equipment (such as wheelchairs, walkers, crutches) as follows:

- Rental of durable medical equipment. Instead of rental, the plan may cover purchase of this equipment if Aetna is shown that long-term use of it is planned and that it either can't be rented or would cost less to purchase than to rent;
- Repair of purchased durable medical equipment;
- Replacement of purchased durable medical equipment if Aetna is shown that it is needed because of a change in the person's physical condition, or if it is likely to cost less to purchase a replacement than to repair existing equipment or rent similar equipment.

Diabetic Equipment, Supplies and Education

The plan covers the following services, supplies, equipment and training for the treatment of diabetes:

- Diabetic education;
- Insulin preparations;
- Insulin infusion pumps;
- Needles and syringes;
- Injection aids;
- Blood glucose monitors and test strips;
- Lancets;
- Prescribed oral medications for controlling blood sugar level;
- Alcohol swaps;
- Glucose agents;
- Glucagon emergency kits or injectable glucagon;
- Self-management training provided by a qualified health care provider; and
- Orthotic devices, orthopedic shoes and replacement inserts.

Other Covered Expenses

The plan also covers:

- Charges for drugs and medicines which, by law, require a physician's prescription, but only while a person is confined as an inpatient.
- Charges for diagnostic lab work and x-rays; x-ray, radium and radioactive isotope therapy; and anesthetics and oxygen.
- Artificial limbs and eyes. Not included are such things as eyeglasses, vision aids, hearing aids and communication aids.
- Anesthetics and oxygen.
- Inpatient and outpatient charges for the surgical treatment of morbid obesity if precertified and approved through the City of Fort Worth.

Prescription Drug Benefits

Outpatient prescription drugs prescribed by a physician to treat an illness or injury are covered.

To receive maximum benefits there are two ways to fill prescriptions: at an in-network retail pharmacy or by mail order through Aetna RX Home Delivery. The amount you pay for your prescription depends on whether the drug is generic or brand-name, or if it is in the formulary. Although you may also fill a prescription at an out-of-network retail pharmacy, the benefits you receive will be reduced.

The formulary is a list of preferred drugs that includes both brand-name and generic drugs. You can reduce your co-payment by using a covered drug that appears on the formulary.

You can find Aetna's formulary online at www.aetna.com/formulary or call Member Services at the number on your ID card to request a printed formulary guide.

Retail Pharmacy

You may fill your prescription for up to a 30-day supply at a pharmacy that belongs to Aetna's pharmacy network.

There is no benefit for prescriptions obtained at out-of-network retail pharmacies.

You can find a list of in-network pharmacies using the DocFind tool on Aetna Navigator.

Mail Order Prescriptions

If you take medications on a regular basis, you may order up to a 90-day supply through Aetna Rx Home Delivery, Aetna's mail order drug service. Aetna Rx Home Delivery is easy-to-use and saves you money.

To order by mail, send your original prescription, together with an order form and payment of the applicable coinsurance amount to Aetna. Order forms are available online at www.aetnarxhomedelivery.com. Your doctor can also fax a prescription and order form to 866-681-5166.

Refills can be ordered by mail, online at www.aetnarxhomedelivery.com or by phone toll free at 800-227-5720. The address is P.O. Box 829518, Pembroke Pines, FL 33082-9913.

What the Prescription Drug Program Covers

The following prescription drug expenses are covered:

- Federal legend drugs – drugs that require a label stating: “Caution: Federal law prohibits dispensing without a prescription”;
- Compounded medications, of which at least one ingredient is a federal legend drug;
- Any other drug which, under applicable state law, may be dispensed only upon a physician’s written prescription;
- Insulin needles and syringes;
- Insulin;
- Contraceptive drugs;
- Drugs to treat erectile dysfunction, up to 6 tablets per month.

What the Prescription Drug Program Does Not Cover

The following prescription drug expenses are not covered:

- Any drug that does not, by federal 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;
- A device of any type (such as a spacer or nebulizer) used in connection with a prescription drug;
- Any drug entirely consumed when and where it is prescribed;
- Administration or injection of any drug;
- More than the number of refills specified by the prescribing doctor;
- Any refill of a drug dispensed more than one year after prescribed, or as permitted by law where the drug is dispensed;
- Oral and injectable fertility drugs;
- Immunization agents;
- Smoking cessation aids;
- Nutritional supplements.

Women's Health Provisions

Federal law affects how certain health conditions are covered. Your rights under these laws are described below.

The Newborns' and Mothers' Health Protection Act

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

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

Finally, federal law states that a plan may not require a **physician** or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, pre-certification may be required for more than 48 or 96 hours of confinement.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires that the following procedures be covered for a person who receives benefits for a medically **necessary** mastectomy and decides to have reconstructive surgery after the mastectomy:

- 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 lymphedemas.

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

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

Special Programs

As participants in this plan, you and your covered family members can take advantage of the special care, discount, vision and fitness programs described in this section. These services, discounts and programs are not underwritten by Aetna, but are made available to you and your family as part of your plan.

The National Medical Excellence Program® (NME)

The National Medical Excellence (NME) Program® helps you and covered family members receive care from nationally recognized doctors and facilities specializing in organ transplants and certain other treatments. For patients who take part in this program, the plan pays benefits for covered medical expenses incurred for the NME procedures and treatment types listed in this section. In addition, the plan pays a benefit for travel and lodging expenses when the patient is directed to care at a facility more than 100 miles from his/her home.

Institutes of Excellence™ Network

The Institutes of Excellence Network supports the NME program. It is Aetna's network of health care facilities for transplants and transplant-related services, including evaluation and follow-up care. Aetna selects hospitals for the network based on successful clinical outcomes, quality of care standards and agreement with Aetna's contractual terms. These facilities have been contracted on a transplant-specific basis and are, therefore, considered preferred only for specific transplant types. The plan pays benefits at the plan's regular coinsurance for transplant-related services, including evaluation, transplant and follow-up care, when patients use an Institutes of Excellence participating facility that has been specifically contracted by Aetna for their transplant type. Transplants performed outside of the Institutes of Excellence Network will be also paid at the plan's regular coinsurance.

You can find a list of Institutes of Excellence facilities at DocFind or from Member Services at the number on your ID card.

NME Procedure and Treatment Types

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

Travel Expenses

“Travel expenses” are expenses for transportation between the patient’s home and the medical facility where he or she receives services in connection with a procedure or treatment listed above. Also included are expenses incurred by a **companion** for transportation to and from an NME patient’s home and the medical facility where he or she receives services. These expenses must be approved in advance by Aetna.

Lodging Expenses

These are expenses for lodging away from home while a patient is traveling between his or her home and the medical facility where services are provided. The plan covers the patient’s lodging expenses up to \$50 per person, per night.

Also covered are a **companion**’s expenses for lodging away from home:

- While traveling with an NME patient between the patient’s home and the medical facility where services are provided; or
- When the patient needs a companion’s help to receive services from the medical facility on an inpatient or outpatient basis.

The plan covers a **companion**’s lodging expenses up to \$50 per person, per night. For the purpose of determining NME travel or lodging expenses, the hospital or other temporary residence to which a patient must travel while receiving treatment or after discharge at the end of treatment, will be considered the patient’s home.

Travel and Lodging Maximum

The plan pays up to \$10,000 per episode of care for travel and lodging expenses incurred in connection with a procedure or treatment. Benefits will be paid only for expenses incurred during the period that begins on the day a covered person becomes an NME patient and ends on the earlier to occur of the following:

- One year after the day the procedure is performed;
- The date the patient stops receiving services from the facility in connection with the procedure.

Limitations

Travel and lodging expenses include only those expenses described in this section. No other type of expense covered under this plan will be considered a travel or lodging expense. In addition, the plan covers travel and lodging expenses for just one **companion** unless the patient is a minor in which case up to two companions over age 18 are allowed.

Informed Health[®] Line

At any time, you can call 1-800-556-1555 to speak to Informed Health Line nurses. Our registered nurses are experienced in providing information on a variety of health topics. While the nurses don't diagnose problems, prescribe or give advice, they can:

- Help you understand health issues and treatment choices,
- Give you some good questions to ask your doctor, and
- Tell you about the latest research on certain treatments and procedures, and explain their risks and benefits.

The nurses can help you make sense of your health issues and communicate better with your doctor. They'll give you the facts you need to make decisions and choices you can feel good about.

Informed Health Line also includes an audio health library that gives you an easy way to access reliable health information from any touchtone phone, 24 hours a day, in English or Spanish.

What the Medical Plan Does Not Cover

This section contains a general list of charges not covered under the plan. These excluded charges will not be used when figuring benefits. (Remember, limitations and exclusions for specific types of health care expenses are contained in the section, *What the Medical Plan Covers*.)

Exclusions listed in this section will not apply if coverage is required by law. Also, if a benefit is prohibited by the law of the jurisdiction where a person lives, it will not be paid.

General Exclusions

The plan does *not* cover charges:

- For services and supplies Aetna determines are not necessary for the diagnosis, care or treatment of the disease or injury involved – even if they are prescribed, recommended or approved by a physician or dentist.
- For care, treatment, services or supplies not prescribed, recommended or approved by a physician or dentist.
- For services of a resident physician or intern.
- Made only because you have health coverage.
- You are not legally obligated to pay.
- That are not reasonable and customary charges, as determined by Aetna.

Experimental or Investigational

Except as provided below, the plan does not cover drugs, devices, treatments or procedures that are experimental or investigational. A drug, device, treatment or procedure is considered experimental or investigational if:

- It requires approval by a governmental authority (including the U.S. Food and Drug Administration) prior to use, but such approval has not been granted; or
- It is the subject of a written protocol used by any facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or maximum tolerated dose, as evidenced in the protocol itself or in the written consent form used by the facility; 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, as these Phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services; or
- It has not been proven safe and effective under generally accepted standards of medical practice.

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

However, your plan will pay for experimental or investigational drugs, devices, treatments or procedures if *all* of the following conditions are met:

- You have been diagnosed with a cancer or a condition that is likely to cause death within one year;
- Standard therapies have not been effective or do not meet the definition of medically necessary;
- Aetna determines, based on at least two documents of medical and scientific evidence that you would likely benefit from the treatment; and
- You are enrolled in a clinical trial that meets *all* of 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 (e.g. Food & Drug Administration, Department of Defense) and conforms to the NCI standards,
 - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center, and
 - You are treated according to the protocol.

Government and Armed Forces

The plan does *not* cover charges (to the extent allowed by law) for services and 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.
- Provided, paid for, or for which benefits are provided or required under any governmental law. This exclusion will not apply to “no fault” auto insurance if it is:
 - Required by law; and
 - Provided on an individual basis; and
 - Included in the definition of “other plan” in the section, *Coordination With Other Plans*.

This exclusion also will not apply to a plan established by government for its own employees or their dependents, or to Medicaid.

Education and Training

The plan does *not* cover charges for:

- Services, treatment, education testing or training related to learning disabilities or developmental delays.
- Education, special education or job training, whether or not this is provided in a facility that also provides medical or psychiatric treatment.

Reproductive and Sexual Health

The plan does *not* cover charges for:

- Therapy, supplies or counseling for sexual dysfunction or inadequacies that don't have a physiological or organic basis.
- Sex change surgery or treatment of gender identity disorders.
- Reversal of a sterilization procedure.
- Voluntary abortion.
- Drugs used to treat erectile dysfunction, impotence or sexual dysfunction or inadequacy. 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).

Mental Health

The plan does *not* cover charges for:

- Marriage, family, child, career, social adjustment, pastoral or financial counseling.
- Treatment of health care providers who specialize in mental health and receive treatment as part of their training in that field.
- Primal therapy, rolfing or psychodrama.

Custodial and Protective Care

The plan does not cover charges for:

- Care provided to create an environment that protects a person against exposure that can make his or her disease or injury worse.
- **Custodial care**; that is, care provided to help a person in the activities of daily life.

Cosmetic Procedures

Regardless of whether the service is provided for psychological or emotional reasons, the plan does *not* cover charges for:

- Plastic surgery;
- Reconstructive surgery;
- Cosmetic surgery; or
- Other services that improve, alter or enhance appearance, whether or not for psychological or emotional reasons . . .

. . . ***except*** when needed:

- To improve the function of a part of the body that:
 - Is not a tooth or a structure that supports the teeth; and
 - Is malformed as a result of a severe birth defect (such as cleft lip, or webbed fingers or toes), disease, or surgery performed to treat a disease or injury.
- As part of reconstruction following an accidental injury. Surgery must be performed in the calendar year of the accident that caused the injury, or in the next calendar year.
- As part of reconstruction following a mastectomy.

Other Services and Supplies

The plan also does not cover:

- Acupuncture except when used in lieu of anesthesia;
- Wigs;
- Blood, blood plasma or other blood derivatives or substitutes, and any related services including processing, storage or replacement costs, and the services of blood donors;
- Disposable outpatient supplies including sheaths, bags, elastic garments, bandages, syringes, blood or urine testing supplies, unless specifically provided under *What the Medical Plan Covers*;
- Food items, nutritional supplements, vitamins, medical foods and formulas, even if they are the sole source of nutrition;
- Household improvements and equipment, including the purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses, waterbeds, ramps, elevators, handrails, stair glides and swimming pools;
- Injectable drugs, if there is an alternative oral drug;
- Recreational therapy;
- Services and supplies provided for personal comfort or convenience, or for the convenience of any other person, including a provider.

Coordination With Other Plans

The Traditional Choice Plan is offered by the City of Fort Worth primarily for its Medicare Retirees. The retirees and their eligible dependents (usually a spouse) must be enrolled in Medicare Part A or Medicare Parts A and B to qualify for this plan.

For medical services covered by Medicare, most of Part A services are covered at 100%. Part B medical services including the deductible are covered at 90%. Enrollee is subject to 10% of the Part B medical services including the deductible. However, amounts paid by Medicare for a service may reduce, or even eliminate, the 10% coinsurance.

Coordination of Benefits Provision

The Coordination of Benefits (COB) for the Traditional Plan and other coverage works as follows:

- A. Enrollee has Medicare and not enrolled in any other plan other than the Traditional Choice Plan.

Medicare is primary, Traditional Plan is secondary.

- B. Enrollee has Medicare and is actively employed and enrolled in employer's plan.

Current employer's plan is primary, Medicare is secondary, and the Traditional Plan pays third.

- C. Enrollee has Medicare, but covered under a working spouse plan.

The working spouse plan is primary, Medicare is secondary, and the Traditional Plan pays third.

- D. Enrollee has Medicare and Tricare.

Medicare is primary, Traditional Plan is secondary, and Tricare pays third.

- E. Enrollee has Medicare and retirement health coverage from another employer.

Medicare is primary, the company that the enrollee retired from first would generally be secondary and the other plan would pay third. The enrollee should contact the Benefits Office of each plan to confirm which would be secondary.

Medical Services Not Covered by Medicare

The Traditional Plan will be primary in all coverage possibilities above except B and E. The coinsurance amount for the enrollee is generally 10% and the coinsurance out-of-pocket maximum for the calendar year is \$2,000.

Right to Receive and Release Information

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

Facility of Payment

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

Right of Recovery

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

Claims and Benefit Payment

This section explains the rules and provisions that affect claim filing and processing, and payment of benefits.

Keeping Records of Expenses

It's important to keep records of medical expenses for yourself and all covered family members. These will be required when you file a claim for benefits. Of particular importance are:

- Names and addresses of physicians;
- The dates on which expenses are incurred; and
- Copies of all medical bills and receipts.

Filing Claims

Medicare Direct

Each enrollee that submits a copy of their Medicare card to the City's Human Resources Benefits Division will be enrolled into Aetna's Medicare Direct. This enrollment will alert Medicare that Aetna is the Enrollee's secondary payer.

All providers accepting the Medicare allowable amount are required to file the initial claim with Medicare. After Medicare has paid its share of the expenses submitted by the provider (Part B medical services only), Medicare forwards your remaining expenses directly to Aetna. This process is transparent and a benefit to the enrollee.

Not Enrolled in Medicare Direct

You must file a claim to be reimbursed for covered expenses. To file a claim, you complete a claim form. (Claim forms are available on Aetna Navigator at **www.aetna.com** or by calling Aetna Member Services.) The form contains instructions on how and when to file a claim, as well as the address to which you should send your completed form.

Claims should be submitted to:

Aetna
P.O. Box 14586
Lexington, KY 40512-4586

When you visit a NAP provider, allow the provider to submit the claim. After your claim is processed at the discounted rate, you'll be billed for any applicable coinsurance or non-covered service.

All claims must be filed promptly. Your deadline for filing a claim is 12 months after the date you incurred a covered expense. If, through no fault of your own, you are unable to meet this deadline, your claim will still be accepted if you file as soon as possible. However, if a claim is filed more than two years after the deadline, it will not be covered unless you are legally incapacitated.

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative. An “authorized representative” is a person you authorize, in writing, to act on your behalf. The plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

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. Turn to the section, *When You Disagree With a Claim Decision*, for more information about appeals.

Time Frames for Claim Processing

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

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown in the following chart. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see *When You Disagree With a Claim Decision* for more information about appeals.

Type of Claim	Response Time
<p>Urgent care claim: a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> • 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. 	As soon as possible, but not later than 72 hours
<p>Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care (pre-certification).</p>	15 calendar days
<p>Concurrent care claim extension: a request to extend a previously approved course of treatment.</p>	<ul style="list-style-type: none"> • Urgent care claim - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment. • Other claims - 15 calendar days
<p>Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.</p>	With enough advance notice to allow you to appeal
<p>Post-service claim: a claim for a benefit that is not a pre-service claim.</p>	30 calendar days

Extensions of Time Frames

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

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

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

Payment of Benefits

Benefits will be eligible for payment as soon as Aetna receives the necessary proof to support the claim. All benefits are payable to you or the provider.

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. More information about appeals follows later in this section.

When You Disagree With a Claim Decision

The Appeal Process

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

Written requests for appeal may be sent to:

Aetna
P.O. Box 14586
Lexington, KY 40512-4586

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

Type of Claim	Level One Appeal Response Time	Level Two Appeal Response Time
<p>Urgent care claim: a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> • 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. 	<p>36 hours</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>	<p>36 hours</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>
<p>Pre-service claim: a claim for a benefit that requires Aetna’s approval of the benefit in advance of obtaining medical care.</p>	<p>15 calendar days</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>	<p>15 calendar days</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>
<p>Concurrent care claim extension: a request to extend a previously approved course of treatment.</p>	<p>Treated like an urgent care claim or a pre-service claim depending on the circumstances.</p>	<p>Treated like an urgent care claim or a pre-service claim depending on the circumstances.</p>
<p>Post-service claim: a claim for a benefit that is not a pre-service claim.</p>	<p>30 calendar days</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>	<p>30 calendar days</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>

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 case 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 more information.

Voluntary Appeals

You may file a voluntary appeal after the standard appeals process has been exhausted. The voluntary appeal should be made to the City of Fort Worth.

You must complete all levels of the standard appeal process before you can appeal to the City of Fort Worth. You, or your authorized representative, must request the voluntary level of review within 60 days after you receive the final denial notice under the standard appeal proves.

If you file a voluntary appeal, any applicable statute of limitations will be suspended while the appeal is pending. Since this level of appeal is voluntary, you are not required to pursue it before initiating legal action.

You must submit your voluntary appeal to the City of Fort Worth in writing and include:

- The reason for the appeal;
- Copies of all past correspondence with Aetna (including your Explanation of Benefits; and
- Any applicable information that you have not yet sent to Aetna.

The City of Fort Worth has the right to obtain information from Aetna that is relevant to your claim.

The City of Fort Worth will review your appeal and make a decision within 60 days after you file your appeal. If the City of Fort Worth reviewer needs more time, the reviewer may take an additional 60 days. You will be notified in advance of this extension.

The City of Fort Worth's reviewer will notify you of the final decision on your appeal electronically or in writing. The notice will give you the reason for the decision and the Plan provisions upon which the decision was based.

All decisions by the City of Fort Worth will be final and binding.

Claim Fiduciary

The City of Fort Worth has discretionary authority to review all denied claims for benefits under the medical plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, the City of Fort Worth has discretionary authority to:

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

Aetna has the right to adopt reasonable policies, procedures, rules and interpretations of the plan to promote orderly and efficient administration. Aetna may not abuse its discretionary authority by acting arbitrarily and capriciously.

The City of Fort Worth is responsible for making reports and disclosures required by applicable laws and regulations.

Subrogation and Reimbursement

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term Responsible Party includes the liability insurer of such party, or any insurance coverage.

For purposes of this provision, the term Insurance Coverage refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

For purposes of this provision, a Covered Person includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

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

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, 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 for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, 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, the Covered Person; the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative agent; and/or any other source possessing funds representing the amount of benefits paid by the plan or the City of Fort Worth.

First-Priority Claim

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

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 by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

Cooperation

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

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

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The plan reserves the right to notify Responsible Party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

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.

Jurisdiction

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

When Coverage Ends

Your coverage under this plan can end for a number of reasons. This section explains how and why your coverage can be terminated, and how you may be able to continue coverage after it ends.

For Retired Employees

Your coverage under this plan ends at the end of the period for which contributions were made following the date:

- You terminate your coverage;
- The coverage described in this booklet is terminated under the group contract;
- You are no longer in an eligible class for all or part of your coverage; or
- You fail to make any required contribution.

For Dependents

Your dependent's coverage will end on the earliest to occur of the following events:

- When all dependents' coverage under the group contract is terminated;
- When a dependent becomes covered as an employee of the City of Fort Worth (a person cannot be covered as both an employee and a dependent);
- The end of the month when he or she no longer meets the plan's definition of a dependent (see the *Eligibility* section); or
- When your coverage terminates.

Continuing Coverage under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your dependents have the right to continue health coverage if it ends for the reasons ("qualifying events") described below. You may continue only the plan coverage in effect at the time and must pay required premiums.

Qualifying Events and Continuation Periods

The chart below outlines:

- The qualifying events that trigger the right to continue coverage;
- Those eligible to elect continued coverage; and
- The maximum continuation period.

Qualifying Event Causing Loss of Coverage	Covered Persons Eligible for Continued Coverage	Maximum Continuation Period
Divorce or legal separation	Your spouse Your dependent children	36 months
Children no longer qualify as eligible for dependent coverage	Your dependent children	36 months
Your death	Your spouse Your dependent children	36 months

The required premium for the 18- or 36-month continuation period may be up to 102% of the plan cost.

Disability Extension

The 18-month continuation period may be extended for an additional 11 months if you or your covered dependents qualify for disability status under Title II or XVI of the Social Security Act during the 18-month continuation period. The additional 11 months of continued coverage is available for the disabled individual and any family member of the disabled person.

The City of Fort Worth must be notified of a determination of disability within 60 days of the date of the determination and before the end of the 18-month continuation period.

The required premiums for the 18th through 29th month of continued coverage may be up to 150% of the plan cost.

Multiple Qualifying Events

If your spouse or dependent children experience a second qualifying event during the 18- or 29-month continuation period, their maximum continuation period can be extended to 36 months.

Electing Continued Coverage

The City of Fort Worth will notify Aetna who will give you detailed information about how to continue coverage under COBRA at the time you or your dependents become eligible. You or your dependents will need to elect continued coverage within 60 days of the “qualifying event” or the date of your COBRA notice, if later. The election must include an agreement to pay required premiums.

Your dependents will need to notify the City of Fort Worth within 60 days of a divorce or legal separation or loss of dependent child eligibility, or the date coverage ends due to those circumstances, if later.

When COBRA Continuation Ends

Continued coverage ends on the first of the following events:

- The end of the maximum COBRA continuation period;
- Failure to pay required premiums;
- Coverage under another group plan that does not restrict coverage for preexisting conditions;
- Coverage by Medicare;
- The City of Fort Worth no longer offers a group health plan;
- You or your dependents die.

Other Continuation Provisions

If this plan contains any other continuation provisions, contact the City of Fort Worth for information on how they may affect COBRA continuation provisions.

Your Privacy Under HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 gives you certain rights of privacy concerning your health information.

The regulation designates certain medical information as Protected Health Information (PHI). PHI is any information that could be used to identify you as an individual in electronic, printed or spoken form. PHI consists of information that relates to past, present or future health or physical or mental conditions.

You have the right to:

- Receive notice of your privacy rights, policies and procedures;
- Obtain access to your PHI;
- Amend your PHI;
- Authorize use and disclosure of your PHI;
- Receive an accounting of uses and disclosures of your PHI;
- Receive communications by an alternative means or at an alternative location.

Your health care providers must obtain your written consent to use or disclose your PHI for any purpose other than:

- Treatment;
- Payment;
- Health care operations; or
- As required by a national public health initiative, law enforcement investigations and other such laws (e.g., Occupational Safety and Health Administration regulations).

There are also times when your PHI may be used or disclosed without your consent. These permitted uses include disclosure:

- To you;
- In case of an emergency where your provider cannot get authorization;
- When treatment is required by law;
- Where language barriers exist but consent can be inferred;
- Pursuant to an authorization from you;
- To business associates (consultants and other entities who contract with the City of Fort Worth and comply with the privacy rules); and
- When all information that could identify you is removed from your PHI.

You may be asked to authorize your PHI for another purpose. When you grant this authorization, your PHI is still protected from use and disclosure by any party other than the one(s) to whom you grant written authorization, and from use and disclosure by authorized parties for any purpose other than the one you specifically authorized.

Other Plan Provisions

Type of Coverage

Only non-occupational (not job-related) accidental injuries and **non-occupational diseases** are covered under this plan. Coverage for services and supplies applies only if they are provided to a person at the time he or she is covered under the plan.

Multiple Coverage and Misstatement of Fact

You cannot be covered under this plan as both a retiree and as a dependent.

If there is a misstatement of fact that affects your coverage under this plan, the true facts will be investigated to determine the coverage that applies.

Assignment of Coverage

Coverage may be assigned (signed over to another person) only with Aetna's written permission.

Glossary

The terms that appear in bold print throughout this booklet are defined in this section.

Brand-Name Drug

This is a prescription drug protected by trademark registration.

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.

Co-pay/Co-payment

This is a flat fee, which represents a portion of the applicable expenses.

Custodial Care

This means services and supplies – including room and board and other institutional care – provided to help a person in the activities of daily life. The person does not have to be disabled. Such services and supplies are custodial care no matter who prescribes, recommends or performs them.

Durable Medical Equipment

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

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or injury; and
- Suited for use in the home.

Effective Treatment of Alcoholism or Drug Abuse

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a physician 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 alcoholism or drug abuse.

Detoxification (treating the aftereffects of a specific episode of alcohol or drug abuse) and maintenance care (providing an alcohol- and/or drug-free environment) are not considered “effective treatment.”

Emergency Admission

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

- Which requires confinement right away as a full-time inpatient; and
- For which, if immediate inpatient care were not given, could (as determined by Aetna), reasonably be expected to result in:
 - Placing the person’s health in serious jeopardy; or
 - Serious impairment to bodily function; or
 - 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 in a hospital’s emergency room to evaluate and treat medical conditions of a recent onset and severity – including but not limited to severe pain – which would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person’s health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- 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 – which would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

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

Some examples of emergency conditions include:

- Serious injury, severe pain or infection;
- Poisoning;
- Uncontrollable bleeding;
- Sudden change of vision;
- Chest pain;
- Sudden weakness or trouble talking;
- Major burns;
- Spinal injury;
- Difficulty breathing;
- Broken bones.

Home Health Care Agency

This is an agency that:

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

Home Health Care Plan

This is a plan that provides for care and treatment in a person's home. It must be:

- Prescribed in writing by the attending physician; and
- An alternative to confinement in a hospital or convalescent facility.

Hospice Care

This is care 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 which include:
 - Physician services; and
 - Physical and occupational therapy; and
 - Part-time home health aide services which mainly consist of caring for terminally ill people; and
 - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
 - One physician; and
 - One R.N.; and
 - One licensed or certified social worker employed by the agency.
- Establishes policies about how hospice care is provided.
- Assesses the patient's medical and social needs.
- Develops a hospice care program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Facility

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

- Mainly provides inpatient hospice care to terminally ill persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians. At least one staff physician must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of a R.N.
- 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 the person's 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.
- Includes an assessment of the person's 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 R.N. service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Charges for its services.

L.P.N.

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 mental health professional such as a psychiatrist, psychologist or psychiatric social worker. Mental disorders include (but are not limited to):

- Alcoholism and drug abuse
- Schizophrenia
- Bipolar disorder
- Pervasive mental developmental disorder (autism)
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

For the purposes of benefits under this plan, mental disorder will include alcoholism and drug abuse only if there is no separate benefit for the treatment of alcoholism and drug abuse.

Necessary

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

To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- Be a diagnostic procedure, indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

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

- Information provided on the person's health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Aetna's attention.

The following services or supplies are not considered necessary:

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

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 the person:

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

Non-occupational Injury

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

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

Physician

The following practitioners are recognized as legally qualified physicians when they are rendering a covered service:

- Medical Doctor (M.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Dental Surgery (D.D.S.) or Dentist (D.D.S.)
- Podiatrist (D.P.M.), (D.S.C.)
- Doctor of Chiropractic (D.C.)
- Licensed Professional Counselor (L.P.C.)
- Optometrist (O.D.)
- Psychologist (Ph.D.), (Ed. D.)
- Social Worker (M.S.W.)

Prescription Drugs

Any of the following:

- A drug, biological or compounded prescription which, by federal law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable 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..
- Disposable needles and syringes purchased to administer a covered injectable prescription drug.

R.N.

This means a registered nurse.

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.

If a hospital or other health care facility doesn't identify the specific amounts charged for room and board charges and other charges, Aetna will assume that 40% of the total is the room and board charge, and 60% is other charges.

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 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
 - Professional nursing care by a R.N., or by a L.P.N. directed by a full-time R.N.; and
 - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for people who are mentally retarded, for custodial or educational care, or for care of mental disorders.
- Charges for its services.

Terminally Ill

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

Treatment Facility (Alcoholism or Drug Abuse)

This is an institution that:

- Mainly provides a program for diagnosis, evaluation and effective treatment of alcoholism or drug abuse.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs, and must be supervised by a physician.
- Provides, on the premises, 24 hours a day:
 - Detoxification services needed with its effective treatment program.
 - Infirmiry-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 directed by a full-time R.N.