Preferred Provider Organization (PPO)
Benefits Handbook:  High PPO Option

January 1, 2013
Understanding your benefits is important. Knowing what’s covered and not covered, and how your coverage works is essential when making decisions about health care – whether you’re faced with a serious illness or injury, or seeking routine medical services. This handbook can help you learn about the High PPO option offered under the AMETEK, Inc. Health and Welfare Plan.

You are eligible for the benefits described in this handbook if the High PPO option is available at your location to the employees in your class (i.e., salaried or hourly).

**Type of Benefit:** Medical – Preferred Provider Organization (PPO)

**Network Administrator:** Aetna Life Insurance Company

**Network Type:** Choice POS II

**Network Website:** [www.aetna.com](http://www.aetna.com)

**Benefit Effective Date:** January 1, 2013

**Document Reference Code:** AMEFlex High PPO Option

### About This Book

The Employee Retirement Income Security Act of 1974, as amended (known as ERISA), requires AMETEK, Inc. (AMETEK) to issue a Summary Plan Description (SPD) describing the benefits provided to eligible employees. This handbook, together with the *AMETEK, Inc. Health and Welfare Plan Overview Booklet*, is the SPD for the High PPO option (the Plan). In the handbook, you’ll find:

- What the Plan covers and does not cover;
- Tools and resources to help you use your medical plan coverage to full advantage;
- How to file a claim or appeal a claim decision;
- Information about how the Plan coordinates its benefits with other plans; and
- Definitions of key terms.

For information about eligibility, when coverage starts and ends, your ERISA rights and other general information, refer to the *AMETEK, Inc. Health and Welfare Plan Overview Booklet*.

Please read this handbook carefully and refer to it when you need to understand how your medical benefits work. If you have questions or need help:

- Refer to [Benefit Resources and Tools](#); or
- Call the Integrated Aetna Service Center at **1-888-263-8351** (select option 2).
This handbook takes the place of any prior oral or written communication on the subject of the benefits described in this handbook. In the case of any conflict between the terms of the Plan document and this summary or any other oral or written explanation of the Plan’s terms by any AMETEK (including its divisions or subsidiaries) employee, agent or representative, the Plan document will control.

These benefits and the language used in this handbook are not intended to create binding conditions or terms between AMETEK and any of its employees for employment or employee benefits. All employment is “at will.”

AMETEK reserves to itself or its designee the right to change or terminate the Plan or any of the Plan benefits at any time to the extent permitted by law.

If you have any questions about your benefits, please call the Integrated Aetna Service Center at 1-888-263-8351 (select option 2).

**Understanding the Terms**

Words and phrases that appear in **bold type** the first time they appear in a chapter are defined in the [Glossary](#).
# OVERVIEW

- Network and Out-of-Network Coverage .......................................................... 1
- What Advantages Does the PPO Network Offer? .......................................... 1
- What Is a Network? What Are Network Benefits? ........................................ 1
- How Do I Choose a Network Provider? .......................................................... 2
- What Are the Advantages of Electing a Primary Care Physician? .................. 2
- What If I Can’t Find a Physician in the Network With a Particular Specialty? .... 2
- What Does the Network Administrator Do? .................................................. 2
- What Are Out-of-Network Benefits? ................................................................. 2
- Are There Other Rules? ................................................................................. 3
- What Benefits Are Excluded Under This Plan? ............................................. 3

# BENEFIT RESOURCES AND TOOLS .................................................................. 4

- Resources ........................................................................................................ 4
- Tools ............................................................................................................... 5
  - Online Directory .......................................................................................... 5
  - Health Information Website ......................................................................... 6
  - Informed Health® Line ................................................................................ 8
  - Clinical Policy Bulletins ............................................................................. 8
- Special Programs .............................................................................................. 9
  - Care Management ....................................................................................... 9
  - Transplant and Special Medical Care .......................................................... 9
  - Health Management Programs .................................................................. 10
  - Advanced Illness Resources ...................................................................... 12
  - Discount Programs ..................................................................................... 12

# SUMMARY OF BENEFITS ................................................................................. 13

# NETWORK BENEFITS ....................................................................................... 22

- How Network Benefits Work ......................................................................... 22
- The Provider Network ................................................................................... 22
- Primary Care .................................................................................................. 22
- It’s Your Choice .............................................................................................. 22
- Sharing the Cost of Network Care ................................................................. 23
- Copay (copayment) ........................................................................................ 23
WHAT THE PLAN COVERS .................................................................................. 31
  Preventive Care ......................................................................................... 31
  Preventive Physical Exams ........................................................................ 31
  Preventive Ob/Gyn Exams ......................................................................... 32
  Screening and Counseling Services .......................................................... 32
  Preventive Cancer Screenings .................................................................... 33
  Vision Services .......................................................................................... 33
  Preventive Eye Exams ................................................................................ 33
  Office Visits and Walk-In Clinics ............................................................... 34
  Office Visits .............................................................................................. 34
  Walk-In Clinics .......................................................................................... 34
  Family Planning and Maternity ................................................................. 34
    Voluntary Sterilization ............................................................................. 34
    Contraception Services ........................................................................... 34
    Infertility Services .................................................................................... 35
    Maternity Care ......................................................................................... 36
  Hospital Care .............................................................................................. 38
  Surgery ........................................................................................................ 39
    Acupuncture .............................................................................................. 39
    Anesthesia ................................................................................................ 39
    Bariatric Surgery ....................................................................................... 40
    Oral Surgery .............................................................................................. 40
    Outpatient Surgery ................................................................................... 41
    Pre-Admission Testing .............................................................................. 42

OUT-OF-NETWORK BENEFITS ......................................................................... 27
  How Out-of-Network Benefits Work .......................................................... 27
  Sharing the Cost of Out-of-Network Care .................................................. 27
    Copay (copayment) ................................................................................... 28
    Deductible ................................................................................................. 28
    Coinsurance ............................................................................................... 29
    Out-of-Pocket Maximum ......................................................................... 29
  What Is Covered Out-of-Network .............................................................. 30

Deductible .................................................................................................... 24
Coinsurance .................................................................................................. 24
Out-of-Pocket Maximum ............................................................................. 25
What Is Covered In-Network ........................................................................ 26
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreational Surgery</td>
<td>42</td>
</tr>
<tr>
<td>Transplants</td>
<td>43</td>
</tr>
<tr>
<td>Alternatives to Hospital Inpatient Care</td>
<td>45</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>45</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>45</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>46</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>47</td>
</tr>
<tr>
<td>Emergency and Urgent Care</td>
<td>48</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>48</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>49</td>
</tr>
<tr>
<td>Ambulance</td>
<td>49</td>
</tr>
<tr>
<td>Other Covered Expenses</td>
<td>50</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>50</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>50</td>
</tr>
<tr>
<td>Complex Imaging</td>
<td>50</td>
</tr>
<tr>
<td>Diagnostic X-Ray and Laboratory (DXL) Procedures</td>
<td>51</td>
</tr>
<tr>
<td>Durable Medical and Surgical Equipment</td>
<td>51</td>
</tr>
<tr>
<td>Experimental or Investigational Services</td>
<td>51</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>52</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>53</td>
</tr>
<tr>
<td>Short-Term Rehabilitation</td>
<td>53</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ) Disorder</td>
<td>55</td>
</tr>
<tr>
<td>Women’s Health Provisions</td>
<td>55</td>
</tr>
<tr>
<td>The Newborns’ and Mothers’ Health Protection Act</td>
<td>55</td>
</tr>
<tr>
<td>The Women’s Health and Cancer Rights Act</td>
<td>56</td>
</tr>
<tr>
<td><strong>BEHAVIORAL HEALTH CARE</strong></td>
<td>57</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td>57</td>
</tr>
<tr>
<td>Outpatient Treatment</td>
<td>57</td>
</tr>
<tr>
<td>Partial Confinement</td>
<td>57</td>
</tr>
<tr>
<td>Behavioral Health Exclusions</td>
<td>58</td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUG PROGRAM</strong></td>
<td>60</td>
</tr>
<tr>
<td>Three Copay Levels</td>
<td>60</td>
</tr>
<tr>
<td>Generic and Brand-Name Drugs</td>
<td>60</td>
</tr>
<tr>
<td>The Preferred Drug List</td>
<td>61</td>
</tr>
<tr>
<td>Retail Pharmacy</td>
<td>61</td>
</tr>
<tr>
<td>Network Pharmacy</td>
<td>61</td>
</tr>
</tbody>
</table>
### WHAT THE PLAN DOES NOT COVER

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Procedures: Overview</td>
<td>64</td>
</tr>
<tr>
<td>Subrogation and Reimbursement</td>
<td>63</td>
</tr>
<tr>
<td>Weight Control Services</td>
<td>63</td>
</tr>
<tr>
<td>Vision, Speech and Hearing</td>
<td>63</td>
</tr>
<tr>
<td>Tests and Therapies</td>
<td>63</td>
</tr>
<tr>
<td>Strength and Performance</td>
<td>63</td>
</tr>
<tr>
<td>Reproductive and Sexual Health</td>
<td>63</td>
</tr>
<tr>
<td>Home and Mobility</td>
<td>63</td>
</tr>
<tr>
<td>Health Exams</td>
<td>63</td>
</tr>
<tr>
<td>Government and Armed Forces</td>
<td>63</td>
</tr>
<tr>
<td>Foot Care</td>
<td>63</td>
</tr>
<tr>
<td>Family Planning and Maternity</td>
<td>63</td>
</tr>
<tr>
<td>Education and Training</td>
<td>63</td>
</tr>
<tr>
<td>Custodial and Protective Care</td>
<td>63</td>
</tr>
<tr>
<td>Alternative Health Care</td>
<td>63</td>
</tr>
<tr>
<td>Biological and Bionic</td>
<td>63</td>
</tr>
<tr>
<td>Cosmetic Procedures</td>
<td>63</td>
</tr>
<tr>
<td>General Exclusions</td>
<td>63</td>
</tr>
<tr>
<td>What the Prescription Drug Program Does Not Cover</td>
<td>64</td>
</tr>
</tbody>
</table>

### GENERAL PROVISIONS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precertification</td>
<td>73</td>
</tr>
<tr>
<td>When You Need To Precertify Care</td>
<td>73</td>
</tr>
<tr>
<td>If You Don’t Precertify</td>
<td>73</td>
</tr>
<tr>
<td>Precertification of Behavioral Health Care</td>
<td>73</td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>73</td>
</tr>
<tr>
<td>Subrogation and Reimbursement</td>
<td>73</td>
</tr>
<tr>
<td>Definitions</td>
<td>73</td>
</tr>
<tr>
<td>Right of Recovery</td>
<td>73</td>
</tr>
<tr>
<td>When You Accept Plan Benefits</td>
<td>73</td>
</tr>
</tbody>
</table>

### CLAIMS AND APPEALS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Procedures: Overview</td>
<td>79</td>
</tr>
<tr>
<td>Do I Have To Maintain Records?</td>
<td>79</td>
</tr>
<tr>
<td>How Will Benefits Be Paid?</td>
<td>79</td>
</tr>
</tbody>
</table>
AMETEK, Inc. High PPO Option

When Should I Submit a Request for Benefit Payment? ........................................................................... 79
What If a Claim Is Denied? .......................................................................................................................... 79
Types of Claims ........................................................................................................................................... 80
Filing Claims ................................................................................................................................................. 80
Time Frames for Claim Processing ................................................................................................................. 81
Extensions of Time Frames ............................................................................................................................ 81
Notice of Claim Denial .................................................................................................................................. 82
Appealing a Medical Claim Decision ............................................................................................................. 83
   How to Appeal a Claim Denial – Standard Appeals ................................................................................... 83
   Notice of Decision on Appeal ...................................................................................................................... 84
   Appealing Your Standard Appeal Claim Decision – Voluntary Appeals .................................................. 85
Claim Fiduciary .............................................................................................................................................. 89
If You Have a Complaint About the Network ............................................................................................... 89
Recovery of Overpayment .............................................................................................................................. 89
Legal Action .................................................................................................................................................. 90
Retrospective Record Review ....................................................................................................................... 90
Concurrent Review and Discharge Planning .................................................................................................. 90
   Concurrent Review .................................................................................................................................... 90
   Discharge Planning .................................................................................................................................. 90
COORDINATION WITH OTHER PLANS ................................................................................................. 91
Coordination of Benefits with Other Plans (Except Medicare) .................................................................. 91
   Important Terms ......................................................................................................................................... 91
   Which Plan Is Primary? ............................................................................................................................... 92
   Effect of Other Plan Benefits on This Plan’s Benefits .............................................................................. 94
   Right to Receive and Release Needed Information .................................................................................... 94
   Facility of Payment .................................................................................................................................. 94
   Right of Recovery ..................................................................................................................................... 95
Coordination of Benefits with Medicare ......................................................................................................... 95
   When This Plan Is Primary ......................................................................................................................... 95
   When Medicare Is Primary .......................................................................................................................... 96
   How Medicare Parts A and B Affect Your Plan Benefits ........................................................................ 96
GLOSSARY ..................................................................................................................................................... 97
OVERVIEW

The High PPO option provides medical coverage and pays benefits in two distinct ways: “network” and “out-of-network.” Whenever you seek medical attention, you may choose between network and out-of-network providers and benefits. In order to receive the network level of benefits, you must obtain care from a network provider. If you choose to obtain care from an out-of-network provider, you will then receive benefits at the out-of-network level.

Please Note

The PPO benefits described in this booklet are administered by Aetna Life Insurance Company (Aetna) through their Choice POS II network. Throughout this booklet, wherever you see the term “PPO,” it refers to the Aetna Choice POS II network.

Network and Out-of-Network Coverage

What Advantages Does the PPO Network Offer?

The PPO offers you and your dependents several advantages, including:

- PPO providers offer quality health care for negotiated charges. You are served by excellent community-based physicians and highly respected hospitals. You are not responsible for any expenses that exceed the negotiated charge for a service or supply.
- Your benefit Plan has been enhanced to allow you to pay less out-of-pocket if you use PPO network providers. Therefore, you save while receiving quality health care through PPO network providers.
- You fill out no forms (except for required signatures) with the PPO network. The physician’s office or hospital handles all paperwork for you.

What Is a Network? What Are Network Benefits?

A network is a group of physicians, hospitals and other health care providers that has contracted with a Network Administrator to provide medical services to eligible individuals. AMETEK’s agreement with the Network Administrator makes the network available to covered employees and their dependents.

Each network provider (including hospitals) is an independent contractor. No provider is an agent or employee of the Network Administrator, nor is the Network Administrator or any employee of the Network Administrator an employee or agent of any provider. Each provider will maintain a provider-patient relationship with you and your covered dependents and is solely responsible for services and supplies furnished.

When you receive care from a provider in the network, the Plan generally pays a higher level of benefits than it would pay for care from an out-of-network provider. The Summary of Benefits shows how the Plan’s level of coverage differs when you use network versus out-of-network providers. In most cases, you save money when you use network providers. There are no claim forms.
Network benefits are available when:

- You are treated or examined by a network provider;
- You are directed by your network provider to a medical specialist who is also a network physician;
- You receive eligible ancillary services provided at a network hospital by a non-network radiologist, anesthesiologist, pathologist or emergency room physician;
- You are admitted to, or receive any services at, a network hospital at the direction of your network provider; or
- You need treatment for an emergency condition (refer to Emergency Care for more information).

**How Do I Choose a Network Provider?**

The Network Administrator maintains a list of network providers on their website. To find a network provider in your area:

- **Use DocFind at [www.aetna.com](http://www.aetna.com).** Follow the prompts to select the type of search you want, the area in which you want to search and the number of miles you're willing to travel. You can search the online directory for a specific doctor, type of doctor or all the doctors in a given zip code and/or travel distance. For more about DocFind, turn to Benefit Resources and Tools.
- **Call the Integrated Aetna Service Center.** A service specialist can help you find a network provider in your area. You can also request a printed listing of network providers in your area without charge. You can reach the Integrated Aetna Service Center at 1-888-263-8351 (select option 2).

**What Are the Advantages of Electing a Primary Care Physician?**

You are not required to elect a primary care physician. However, if you do elect a primary care physician, that physician can help manage your care and find specialists in the network.

**What If I Can’t Find a Physician in the Network With a Particular Specialty?**

Under rare circumstances, you may not be able to find a physician in the network with a particular specialty that is needed for your care. If this happens, you should call the Integrated Aetna Service Center at 1-888-263-8351 (select option #2) for assistance.

**What Does the Network Administrator Do?**

The Network Administrator can help you understand your network and out-of-network benefits. The Network Administrator has service specialists who are available to answer your questions about the Plan. For example, a service specialist can help you choose a network provider. Call the Integrated Aetna Service Center at 1-888-263-8351 (select option 2) for help.

**What Are Out-of-Network Benefits?**

Out-of-network benefits are benefits for medically necessary services that are not provided by a network provider. Out-of-network benefits are based on the recognized charge for a service or supply. You may be required to file your own claims and you must make the telephone call required for precertification. (See Claims and Appeals and Precertification for more information.)
Out-of-network benefits generally apply when:

- You are treated by any out-of-network physician; or
- You receive any out-of-network hospital services; or
- You fail in any other way to follow the network rules, unless you receive medical care for an emergency condition, as described in Emergency Care.

**Keep in Mind**

When you receive care from an out-of-network doctor or facility, the Plan will cover that care at the out-of-network benefit level. *It is your responsibility to make sure a provider is in the network before you get care.*

**Are There Other Rules?**

Yes. This chapter gives you only an overview of network and out-of-network benefits. A more complete discussion of network benefits can be found in Network Benefits. Out-of-network benefits are described in more detail in Out-of-Network Benefits. For information about covered expenses, see What the Plan Covers and the Summary of Benefits.

**What Benefits Are Excluded Under This Plan?**

Here are some examples of the services that are not covered under the Plan:

- Charges in excess of Plan limits;
- Experimental and investigational services;
- Eyeglasses, contact lenses and hearing aids;
- Reversal of voluntary sterilization;
- In-vitro fertilization;
- Non-prescription drugs (coverage for prescription drugs is described in the Prescription Drug Program chapter of this handbook); and
- Charges relating to an occupational injury or disease.

A more detailed list of exclusions may be found in What the Plan Does Not Cover.
# BENEFIT RESOURCES AND TOOLS

## Resources

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

<table>
<thead>
<tr>
<th>Resource</th>
<th>Situation</th>
<th>How to Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMETEK Benefits Service Center</td>
<td>Notify the AMETEK Benefits Service Center when:</td>
<td>Phone: 1-888-263-8351 (select option 1)</td>
</tr>
<tr>
<td></td>
<td>➢ You have a qualified life event</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ You want to verify current elections</td>
<td></td>
</tr>
<tr>
<td>Benefits Administration System</td>
<td>Use the Benefits Administration System when:</td>
<td>Online: <a href="http://www.portal.adp.com">www.portal.adp.com</a></td>
</tr>
<tr>
<td></td>
<td>➢ You have a qualified life event</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ You want to verify current elections</td>
<td></td>
</tr>
<tr>
<td>Human Resources</td>
<td>You need to report a change in your name, address or telephone number</td>
<td>Call or visit your local Human Resources Department</td>
</tr>
<tr>
<td>Integrated Aetna Service Center</td>
<td>Contact the Aetna Integrated Service Center when:</td>
<td>Phone: 1-888-263-8351 (select option 2)</td>
</tr>
<tr>
<td></td>
<td>➢ You have questions about the Plan's medical benefits</td>
<td>Online: <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td></td>
<td>➢ You must precertify a service</td>
<td>Mailing address: Aetna</td>
</tr>
<tr>
<td></td>
<td>➢ You have a question about a claim</td>
<td>P.O. Box 981106</td>
</tr>
<tr>
<td></td>
<td></td>
<td>El Paso, TX 79998-1106</td>
</tr>
<tr>
<td>Aetna Navigator</td>
<td>Use your member website when you need:</td>
<td>Online: <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td></td>
<td>➢ Help finding a network provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Eligibility or claim status information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ A replacement ID card</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Access to tools that help you manage your health care</td>
<td></td>
</tr>
</tbody>
</table>
Informed Health® Line

<table>
<thead>
<tr>
<th>Resource</th>
<th>Situation</th>
<th>How to Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed Health® Line</td>
<td>Call the Informed Health Line when you are looking for information about:</td>
<td>Phone: 1-800-556-1555</td>
</tr>
<tr>
<td></td>
<td>- Medical procedures and treatment options</td>
<td>TDD: 1-800-270-2386</td>
</tr>
<tr>
<td></td>
<td>- How to ask the right questions when talking with your health care provider</td>
<td></td>
</tr>
</tbody>
</table>

**Tools**

**Online Directory**

DocFind® is Aetna’s online provider directory. DocFind gives you the most recent information about the doctors, hospitals and other providers in the Aetna network. For each doctor or other health care provider, you can learn about his or her credentials and practice, including education, board certification, languages spoken, office location and hours, and parking and handicapped access.

To access DocFind, go to [www.aetna.com](http://www.aetna.com) and follow the prompts.

**The National Advantage™ Program**

When you receive medical care from out-of-network providers, you may be able to save on the cost of your care by using a provider who participates in Aetna’s National Advantage Program (NAP). This program gives you access to contracted rates for hospital, ancillary facility and physician services.

To find out whether NAP providers are available in your area, you can call the Integrated Aetna Service Center at [1-888-263-8351](tel:1-888-263-8351) (select option 2) or use DocFind at [www.aetna.com](http://www.aetna.com) (select the appropriate provider category and follow the prompts to do your search).

**Keep in Mind**

NAP providers are **not** network providers. Covered services provided by an NAP provider will be paid at the out-of-network benefit level. Your savings will generally be highest if you choose a network provider.
Health Information Website

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

- Print eligibility information;
- Request a replacement ID card;
- Download copies of claim forms;
- Check the status of a claim;
- View and print an Explanation of Benefits (EOB);
- Find benefit balances; and
- Contact the Integrated Aetna Service Center.

You also have 24/7 access to useful tools that help you manage your health care:

- Aetna InteliHealth®, Aetna’s award-winning health website lets you search a wide variety of topics, from specific health conditions and their treatment to the latest developments in disease prevention, wellness and fitness. You can also submit questions to health care experts.

- Aetna SmartSourceSM, a search engine that scans Aetna’s online resources and pulls together information that’s specific to you — based on where you live, the plan you’re enrolled in and your personal profile. Just enter a condition or symptom, and SmartSource will give you links to useful information, such as:
  - A HealthMap® that lets you explore your health topic — including symptoms, treatment options, preventive steps and more — to help you see and plan for the road ahead.
  - The names of local doctors in the Choice POS II network who specialize in treating the condition.
  - Estimated health care costs.
  - Aetna programs and discounts that may help you manage your health care needs.
  - Health articles and tips.

- Cost of Care, a tool that allows you to research the costs of office visits, medical tests and selected medical procedures in your area.

- Health History Report, an easy-to-understand summary of doctor visits, tests, treatments and other health-related activity, based on claim activity. The information is organized by categories such as Names of Doctors and Medical Care. You can print your Health History Report and share it with your doctor.

- Health Topics A-Z, a decision-support tool in the Healthwise® Knowledgebase that provides information on thousands of health-related topics to help you make better decisions about health care and treatment options.

- Hospital Comparison Tool, helps you compare area hospitals on measures that are important to your health.
• **Price-A-Drug**\textsuperscript{SM}, allows you to:
  – Estimate the cost of a prescription drug from a local retail pharmacy or a mail-order pharmacy.
  – Compare the costs of generic and brand-name drugs.

The cost of the drug and your share of the cost shown in Price-a-Drug are estimates, based on your current pharmacy plan and the information that you provide. Several factors, such as the quantity, packaging and manufacturer can affect the actual price charged to you by your pharmacy. As a result, estimated pricing may not be accurate in certain situations.

• **Personal Health Record (PHR)**, gives you online access to personal information, including health alerts, a detailed health summary, and information and tools to help you make informed decisions about your health care. Your PHR combines your claim activity with personal information about your health history that you provide, creating a comprehensive health profile. The more you add to the health summary, such as whether there is a history of cancer in your family or whether you take over-the-counter medications, the better the PHR can help you stay on top of important health issues for you and your family. The PHR will send you and your doctor highly personalized and relevant health care alerts and messages. In real time, it will scan your health data and claims information against evidence and rules-based clinical knowledge, and alert you about possible urgent situations and care gaps. This information can help you and your doctor make the best decisions about health care events.

• **Simple Steps To A Healthier Life\textsuperscript{®},** an online wellness program that offers information and self-help tools for weight loss, stress management and fitness. When you visit the program’s site, you can complete a Health Risk Assessment and receive a personalized action plan with recommended healthy living programs based on your personal health needs.

Your personal data is secure. See **Confidentiality of Personal Information** (below).

• **Welvie**\textsuperscript{TM} is a guide for people who are considering surgery. This interactive tool helps you:
  – Work with your provider to get a diagnosis;
  – Understand your treatment options and alternatives;
  – Identify the risks and benefits of treatment choices; and
  – Decide what’s right for you.

**Confidentiality of Personal Information**

The online tools on Aetna’s member website are secure, so your privacy is protected. Your Health Risk Assessment and other results are not available to AMETEK.
Informed Health® Line

Get the help and information you need to make good health care decisions – 24 hours a day, 7 days a week – through Aetna’s Informed Health Line.

Informed Health’s tools and resources can help you make more informed decisions about your care, communicate better with your doctors, and save time and money, by showing you how to get the right care at the right time.

Call the Informed Health Line at 1-800-556-1555 to:

- Speak directly to a registered nurse about a wide variety of health and wellness topics.
- Listen to an audio health library. It explains thousands of health topics in both English and Spanish. Transfer to a registered nurse at any time during the call.

The online Healthwise® Knowledgebase helps you find out more about a health condition you have or medications you take in easy-to-understand terms. This online resource is available through your secure member website, at www.aetna.com.

Clinical Policy Bulletins

Aetna uses its Clinical Policy Bulletins (CPBs) as a resource when making benefit and claim decisions. CPBs are written on selected health care topics, such as new technologies and new treatment approaches and procedures. The CPBs describe whether Aetna has determined that a service or supply is medically necessary, based on clinical information.

You can find the CPBs at www.aetna.com. The language of the CPBs is technical because it was developed for use in benefit administration, so you should print a copy and review it with your doctor if you have questions. Your doctor has access to the CPBs, too.

Keep in Mind

The CPBs define whether a service or supply is medically necessary, but they do not define whether the service or supply is covered by the Plan. This book, along with other Plan documents, describes what is covered and what is not covered by the Plan.

If you have questions about your coverage, you can contact the Integrated Aetna Service Center at 1-888-263-8351 (select option 2).
Special Programs

The value-added discount and health management programs described in this section support a healthy lifestyle and provide resources in the event of a serious illness.

Care Management

The Aetna In Touch Care℠ program takes a holistic approach to managing health care challenges. The service is optional and available to you at no cost. If you decide to participate, a single nurse serves as your “point person” within Aetna when you have acute (short-term) or chronic (ongoing) health care needs.

<table>
<thead>
<tr>
<th>Services:</th>
<th>For example, your nurse can help you:</th>
</tr>
</thead>
</table>
| Care guidance      | ➢ Identify the care you need  
                      ➢ Coordinate care  
                      ➢ Prepare for a hospital stay  
                      ➢ Plan for recovery after surgery |
| Cost saving tips   | ➢ Find out how to make the best use of your benefit plan  
                      ➢ Get cost comparisons for treatment options |
| Health education   | ➢ Learn tips to stay healthy  
                      ➢ Find resources available through your benefit plan and in your community |

The program lets you work with your nurse by phone or by e-mail, when it’s convenient for you. Your nurse is there as a resource to help you understand your health care needs and navigate the health care system – as always, you and your doctor make the decisions about the health care that’s right for you.

Based on your health history, a nurse may reach out to you and offer the support of the Aetna In Touch Care program. You can also contact Aetna if you think this program could help you:

- Call the Integrated Aetna Service Center at 1-888-263-8351 (select option 2); or
- Send an e-mail to MemberOnlyInquiries@aetna.com.

Transplant and Special Medical Care

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

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

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

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

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

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

Travel and lodging expenses must be approved in advance by Aetna. The Plan does not cover expenses that are not approved.

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**Keep in Mind**

The Plan covers only those services, supplies and treatments considered necessary for your medical condition. The Plan does not cover treatment considered experimental or investigational (as determined by Aetna).

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**Health Management Programs**

**Online Health Assessment**

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

This program features:

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

Tailor the program to meet your needs and lifestyle by choosing the resources that are right for you. Simple Steps to a Healthier Life is secure, so your information is protected and confidential. To get started, log in to your secure member website at [www.aetna.com](http://www.aetna.com).
Keep in Mind
The online tools on Aetna’s member website are secure, so your privacy is protected. Your Health Risk Assessment and other results are not available to AMETEK.

Pregnancy Support
The Beginning Right® Maternity Program helps you stay well throughout your pregnancy and after your baby is born. It provides:

- Information on prenatal care, labor and delivery and newborn care;
- A pregnancy risk survey to find out if you have any health conditions or risk factors that could affect your pregnancy;
- Extra support from obstetrically trained nurse case managers if you’re at risk during pregnancy and after delivery; and
- Smoke-Free Moms-to-Be®, a nicotine-free smoking cessation program designed specifically for pregnant women.

How Do I Get Information About This Program?
As soon as Aetna is notified of your pregnancy, an Aetna nurse calls you to get things started. Or you can call and enroll yourself at: 1-800-CRADLE-1 (1-800-272-3531).

Support to Help You Stop Using Tobacco
The Healthy Lifestyle Coaching Tobacco Free program gives you support to break the smoking or tobacco use habit and live tobacco-free. Your personal wellness coach will help you:

- Figure out quitting strategies that work for you;
- Identify and manage the situations that trigger your tobacco use;
- Address personal concerns, such as maintaining your weight or managing stress while quitting; and
- Find healthy alternatives to replace the feeling you get from smoking.

You decide whether one-on-one or group coaching — or a combination — will work best for you. There’s also 24/7 online peer support that’s moderated by a wellness coach.

To keep you motivated, you can earn rewards for reaching milestones in the program.

Call the Integrated Aetna Service Center at 1-888-263-8351 (select option 2) if you’d like to participate in the program. Aetna may also contact you to suggest the program after you complete the Simple Steps To a Healthier Life® health assessment.
**Advanced Illness Resources**

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

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

Call the Integrated Aetna Service Center at **1-888-263-8351** (select option 2) to talk with a nurse case manager about the Aetna Compassionate Care program. Online support is also available at [www.aetnacompassionatecare.com](http://www.aetnacompassionatecare.com).

**Discount Programs**

You are eligible for discounts on health and wellness services and supplies. To learn more about these discounts, visit your secure member website at [www.aetna.com](http://www.aetna.com).

<table>
<thead>
<tr>
<th>To learn more about….</th>
<th>Visit your secure member website at <a href="http://www.aetna.com">www.aetna.com</a> to read about….</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fitness services</td>
<td>Aetna Fitness℠ discount program</td>
</tr>
<tr>
<td>Hearing services and supplies</td>
<td>Aetna Hearing℠ discount program</td>
</tr>
<tr>
<td>Savings on natural therapies and products</td>
<td>Aetna Natural Products and Services℠ program</td>
</tr>
<tr>
<td>Vision services and supplies</td>
<td>Aetna Vision℠ discount program</td>
</tr>
<tr>
<td>Weight loss products and programs</td>
<td>Aetna Weight Management℠ discount program</td>
</tr>
</tbody>
</table>
SUMMARY OF BENEFITS

Understanding the terms listed below will help you use your benefits wisely. These terms, along with other important terms, are defined in the Glossary.

- The medical plan pays benefits only for care that is medically necessary.
- A **copay** (or copayment) is a flat fee that you must pay at the time you receive certain types of service, such as visits to your physician’s office.
- The **deductible** is the part of your covered expenses you pay before the Plan starts to pay benefits each year.
- The Plan’s **coinsurance** is the percentage of covered expenses that the Plan pays after you satisfy the Plan’s calendar year deductible.
- The **out-of-pocket maximum** is the limit on the amount you pay for covered medical expenses out of your own pocket each year. It includes your medical plan deductible and coinsurance.
- **Network providers** have agreed to charge no more than the **negotiated charge** for a service or supply that is covered by the Plan. You are not responsible for amounts that exceed the negotiated charge when you get care from a network provider.
- The Plan pays out-of-network benefits only for the part of a covered expense that is considered the **recognized charge** (formerly called the reasonable and customary limit).

**Keep in Mind**

If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred that are above the recognized charge. These charges do not apply to your deductible or out-of-pocket maximum.

- **Precertification** is a process that determines whether the services being recommended are covered by the Plan.
These charts summarize the benefits available to you:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$525</td>
<td>$1,050</td>
</tr>
<tr>
<td>Family</td>
<td>$1,050</td>
<td>$2,100</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes deductible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,625</td>
<td>$8,400</td>
</tr>
<tr>
<td>Family</td>
<td>$5,250</td>
<td>$16,800</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td>No maximum</td>
<td>No maximum</td>
</tr>
</tbody>
</table>


**Please Note**

The Summary of Benefits chart includes only a portion of the benefits under this Plan. In all cases, the legal Plan Document will govern.

<table>
<thead>
<tr>
<th>Covered Care</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physical exam by PCP</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ 1 exam per calendar year</td>
<td>Deductible and copay do not apply</td>
<td></td>
</tr>
<tr>
<td>Well-child visits to PCP (includes immunizations and routine hearing screenings)</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ 1st 12 months: 7 exams</td>
<td>Deductible and copay do not apply</td>
<td></td>
</tr>
<tr>
<td>➢ 13-24 months: 3 exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ 25-36 months: 3 exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ age 3-18: 1 exam per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening and counseling</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ obesity</td>
<td>Deductible and copay do not apply</td>
<td></td>
</tr>
<tr>
<td>➢ use of tobacco products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ misuse of alcohol or drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ women’s health screenings and counseling</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The medical plan’s coverage of preventive care follows guidelines that are subject to periodic evaluation and change. You can learn more about preventive care coverage on Aetna’s website at [www.aetna.com](http://www.aetna.com) or by calling the Integrated Aetna Service Center at 1-888-263-8351 (select option 2).
## Preventive Care (cont’d)

<table>
<thead>
<tr>
<th>Covered Care</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations (when not part of routine physical or well-child visit)</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Routine annual Ob/Gyn exam (includes one Pap smear and related lab fees)</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ 1 exam per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine mammogram</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ age 35-39: 1 baseline mammogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ age 40 and over: 1 mammogram per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine prostate screening</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ 1 PSA and DRE per calendar year for men age 40 and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine colorectal cancer screening (for those age 50 and over who are at average risk)</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ sigmoidoscopy: 1 every 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ colonoscopy: 1 every 10 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Vision and Hearing Services

<table>
<thead>
<tr>
<th>Covered Care</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine eye exam</td>
<td>100% after you pay $30 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ 1 exam per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine hearing exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

## Precertification

- Precertification is required for:
  - hospital and treatment facility inpatient confinements
  - alternatives to hospital inpatient confinements

To learn more, refer to [Precertification](#).

- Precertification is the responsibility of:
  - The provider
  - You

- Penalty for failure to precertify:
  - No penalty
  - $1,000

Penalty does not apply to outpatient behavioral health.
### Keep in Mind

The Plan’s benefits for outpatient care that you receive from a network provider will be based on whether the provider is affiliated with, or bills through, a hospital or similar facility (such as a clinic). The outpatient services of a provider that is part of a hospital or similar facility are not subject to the Plan’s office visit copay.

<table>
<thead>
<tr>
<th>Covered Care</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care</strong></td>
<td><strong>Plan Pays</strong></td>
<td></td>
</tr>
<tr>
<td>PCP office visit</td>
<td>100% after you pay $25 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Specialist office visit</td>
<td>100% after you pay $30 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Walk-in clinic</td>
<td>100% after you pay $25 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>- provider not associated with or billing through a hospital (or a similar facility, such as a clinic)</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>- provider associated with or billing through a hospital (or a similar facility, such as a clinic)</td>
<td>100% after you pay applicable office visit copay</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Allergy testing and treatment</td>
<td>100% after you pay applicable office visit copay</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td><strong>Plan Pays</strong></td>
<td></td>
</tr>
<tr>
<td>Voluntary sterilization (men)</td>
<td>100% after you pay $30 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>- physician’s office</td>
<td>100% after you pay $30 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>- outpatient facility</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Voluntary sterilization (women)</td>
<td>100% Deductible and copay do not apply</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Contraceptive counseling</td>
<td>100% Deductible and copay do not apply</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>- first 2 visits in a 12-month period</td>
<td>100% after you pay applicable office visit copay</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>- additional visits</td>
<td>100% after you pay applicable office visit copay</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Covered Care</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td><strong>Family Planning (cont’d)</strong></td>
<td>Plan Pays</td>
<td></td>
</tr>
<tr>
<td>Contraceptive devices and injectables provided and billed by your physician <em>(includes insertion/administration)</em></td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>‣ generic devices/injectables and devices with no generic equivalent</td>
<td>Deductible and copay do not apply</td>
<td></td>
</tr>
<tr>
<td>‣ brand-name</td>
<td>100% after you pay applicable office visit copay</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td><strong>Infertility services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‣ diagnosis and treatment of the underlying cause of infertility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>‣ diagnosis</td>
<td>100% after you pay $30 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>‣ treatment: physician’s office</td>
<td>100% after you pay $30 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>‣ treatment: outpatient facility</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>‣ ovulation induction, artificial insemination and advanced reproductive technologies</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td>Plan Pays</td>
<td></td>
</tr>
<tr>
<td>Routine maternity care* <em>(physician’s services)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‣ initial visit</td>
<td>100% after you pay applicable copay</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>‣ routine prenatal office visits</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>‣ delivery and postnatal care</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
</tbody>
</table>

* The benefits shown here are for routine maternity care and services by your Ob/Gyn, including routine prenatal care, delivery services and postnatal care. Additional services such as laboratory tests and care that is required due to a high risk pregnancy are not considered routine maternity care. Call the Integrated Aetna Service Center at **1-888-263-8351** (select option 2) if you have questions about coverage for care during your pregnancy.
### Covered Care

<table>
<thead>
<tr>
<th>Maternity Care (cont’d)</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast feeding support and supplies</td>
<td>Plan Pays</td>
<td></td>
</tr>
<tr>
<td>➢ lactation counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>visits 1-6 in a 12-month period</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>additional visits</td>
<td>100% after you pay applicable office visit copay</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ breast pumps and supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 manual or electric breast pump per 36-month period</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
</tbody>
</table>

### Hospital Care

*Precertification is required for inpatient care*

<table>
<thead>
<tr>
<th>Inpatient care</th>
<th>Plan Pays</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ hospital room and board and inpatient services</td>
<td>80% after the deductible 60% after the deductible</td>
<td></td>
</tr>
<tr>
<td>(room and board are covered up to the hospital’s semi-private room rate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ inpatient physician services</td>
<td>80% after the deductible 60% after the deductible</td>
<td></td>
</tr>
<tr>
<td>(includes physician, radiology and pathology services)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient care</th>
<th>Plan Pays</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ hospital outpatient services</td>
<td>80% after the deductible 60% after the deductible</td>
<td></td>
</tr>
<tr>
<td>➢ outpatient physician services</td>
<td>80% after the deductible 60% after the deductible</td>
<td></td>
</tr>
<tr>
<td>(includes physician, radiology and pathology services)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Surgery and Anesthesia

<table>
<thead>
<tr>
<th>Plan Pays</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>➢ inpatient</td>
<td>80% after the deductible 60% after the deductible</td>
</tr>
<tr>
<td>(includes surgeon, anesthesiologist, radiologist and pathologist)</td>
<td></td>
</tr>
<tr>
<td>➢ outpatient facility</td>
<td>80% after the deductible 60% after the deductible</td>
</tr>
<tr>
<td>(includes surgeon, anesthesiologist, radiologist and pathologist)</td>
<td></td>
</tr>
<tr>
<td>➢ physician’s office</td>
<td>100% after you pay applicable office visit copay 60% after the deductible</td>
</tr>
</tbody>
</table>

| Anesthesia                   | 80% after the deductible 60% after the deductible |                      |
### Covered Care

<table>
<thead>
<tr>
<th>Alternatives to Hospital Care</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Precertification is required</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility care</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ up to a maximum of 60 days per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>80%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Hospice care (inpatient and outpatient)</td>
<td>100%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Private duty nursing</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ up to 45 8-hour shifts per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Emergency and Urgent Care

<table>
<thead>
<tr>
<th>Emergency and Urgent Care</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care in an emergency room</td>
<td>100% after you pay $135 copay for each visit</td>
<td>100% after you pay $135 copay for each visit</td>
</tr>
<tr>
<td>ER copay waived if you are admitted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-emergency care in an emergency room</td>
<td>50% after the deductible</td>
<td>50% after the deductible</td>
</tr>
<tr>
<td>Urgent care in an urgent care center</td>
<td>100% after you pay $30 copay for each visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Non-urgent care in an urgent care center</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
</tbody>
</table>

### Other Covered Expenses

<table>
<thead>
<tr>
<th>Other Covered Expenses</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ physician’s office (not affiliated with a hospital or similar facility)</td>
<td>100% after you pay applicable office visit copay</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ outpatient facility</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ inpatient</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Chiropractic treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ services of a chiropractor are limited to 30 visits per calendar year</td>
<td>100% after you pay $30 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Complex imaging (includes MRI, PET scan and CT scan)</td>
<td>90%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td></td>
<td>Deductible does not apply</td>
<td></td>
</tr>
</tbody>
</table>
### AMETEK, Inc. High PPO Option

#### Other Covered Expenses

<table>
<thead>
<tr>
<th>Covered Care</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient diagnostic X-ray and lab tests</strong></td>
<td>90%</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>(includes non-routine mammograms)</td>
<td>Deductible does not apply</td>
<td></td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td><strong>Short-term rehabilitation</strong> (physical, occupational, speech)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A combined maximum of 60 visits per calendar year applies to all types of therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ provider not associated with or billing through a hospital or a similar facility (such as a clinic)</td>
<td>100% after you pay $30 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ provider associated with or billing through a hospital or a similar facility (such as a clinic)</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ physical therapy evaluations Evaluations do not apply toward the annual maximum for short-term rehabilitation</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
</tbody>
</table>

#### Behavioral Health Care

**Precertification is required for inpatient care and certain outpatient services**

<table>
<thead>
<tr>
<th>Covered Care</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ office visit</td>
<td>100% after you pay $25 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>➢ outpatient facility</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td><strong>Partial hospitalization</strong></td>
<td>100% after you pay $25 copay per visit</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td><strong>Residential treatment facility</strong></td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
</tr>
<tr>
<td>Covered Care</td>
<td>Network Pharmacy</td>
<td>Out-of-Network Pharmacy</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-Day Supply: Retail, Mail Order or Specialty Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Tier I (most generic drugs)</td>
<td>Plan pays 100%</td>
<td>You pay $10 copay, then the Plan pays 60%. No deductible.</td>
</tr>
<tr>
<td>generic contraceptives*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other Tier 1 drugs</td>
<td>You pay $10 copay</td>
<td>You pay $10 copay, then the Plan pays 60%. No deductible.</td>
</tr>
<tr>
<td>➢ Tier II (drugs on the Preferred Drug List)</td>
<td>You pay $30 copay</td>
<td>You pay $30 copay, then the Plan pays 60%. No deductible.</td>
</tr>
<tr>
<td>➢ Tier III (all other drugs)</td>
<td>You pay $50 copay</td>
<td>You pay $50 copay, then the Plan pays 60%. No deductible.</td>
</tr>
<tr>
<td>31 – 90 Day Supply: Mail Order Pharmacy Only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Tier I (most generic drugs)</td>
<td>Plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>generic contraceptives*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other Tier 1 drugs</td>
<td>You pay $20 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>➢ Tier II (drugs on the Preferred Drug List)</td>
<td>You pay $60 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>➢ Tier III (all other drugs)</td>
<td>You pay $100 copay</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* Coverage includes:
- Generic oral and injectable contraceptives and contraceptive devices;
- Diaphragms and implanted devices (such as IUDs and implantable rods) with no generic equivalent; and
- Generic emergency contraceptives, *when prescribed by a physician.*
NETWORK BENEFITS

How Network Benefits Work

The Provider Network

The Plan gives you the freedom to choose any doctor or other health care provider when you need medical care. How that care is covered and how much you pay out of your own pocket depend on whether the expense is covered by the Plan and whether you choose a network provider or an out-of-network provider.

Doctors, hospitals and other health care providers that belong to Aetna’s network are called network providers. The providers in the network represent a wide range of services, including:

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

When they join the network, providers agree to provide services or supplies for negotiated charges.

To find a network provider in your area:

- Call the Integrated Aetna Service Center, at 1-888-263-8351 (select option 2).

Primary Care

While you are not required to choose a primary care physician (PCP), you and each covered member of your family have the option of selecting an internist, family care practitioner, general practitioner or pediatrician (for your children) to serve as your PCP. Regular preventive care is a key to achieving good health, and a PCP can be your personal health care manager. He or she gets to know you and your medical needs, and can recommend a specialist when you need care that he or she can’t provide. This can be very helpful, since it’s often hard to choose the right specialist.

It’s Your Choice

When you need medical care, you have a choice. You can select a doctor or facility that belongs to the network (a network provider) or one that does not belong (an out-of-network provider).

When you use a network provider, you’ll pay less out of your own pocket for your care. You won’t have to fill out claim forms, because your network provider will file claims for you. In addition, your provider will make the necessary telephone call to start the precertification process when you must be hospitalized or need certain types of care. (See Precertification for more information.)
The Summary of Benefits shows how the Plan’s level of coverage differs when you use network versus out-of-network providers. In most cases, you save money when you use network providers.

**To Get the Most From Your Benefit Plan**

It is your responsibility to make sure that your treating physician and hospital are in the network.

**Sharing the Cost of Network Care**

You share in the cost of your medical care by paying deductibles, copays and coinsurance. The Summary of Benefits shows you how these features apply to covered network medical services and supplies:

- For some services, you pay only a copay, then the Plan pays the remainder of the cost.
- Other services are subject to a deductible and coinsurance. The coinsurance method of payment requires that you pay 100% of all covered medical expenses for the year up to a specified amount called a deductible. Once you meet the deductible, the Plan will begin paying a percentage of the cost of covered expenses.

These terms are defined in the Glossary and discussed in more detail below.

**Copay (copayment)**

A copay, sometimes called a copayment, is a fee that you must pay at the time you receive some types of care. After your copay, the Plan will generally cover the remainder of the cost. For example, each time you visit your network PCP’s office, you pay a $40 office visit copay, then the Plan pays 100% of the negotiated charge.

A copay applies to:

- Network physician office visits:
  - PCP: $25 per visit
  - Specialist: $30 per visit
  The office visit copay is waived for preventive care and for certain women’s health services.
- Emergency room (ER) visits: $135 per visit
- Visits to network urgent care facilities: $30 per visit
- Prescription drug purchases:
  - Retail pharmacy: $10 generic (waived for generic contraceptives)/$30 preferred/$50 all other drugs
  - Mail order pharmacy: $20 generic (waived for generic contraceptives)/$60 preferred/$100 all other drugs

**Keep in Mind**

A copay does not apply toward your deductible or out-of-pocket maximum.
Deductible

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

- **Individual:** The individual deductible applies separately to each covered person in the family. When a person’s deductible expenses reach the $525 individual deductible for network care, the person’s network deductible is met. The Plan then starts to pay that person’s covered network expenses at the applicable coinsurance percentage.

- **Family:** The family deductible applies to the family as a group. When the combined deductible expenses of all covered family members for network care reach the $1,050 family deductible for network care, the family network deductible is met. The Plan then begins to pay benefits for covered network care for all covered family members. All covered family members can contribute toward the family deductible; however, not more than the individual deductible amount per person will be credited to meet the family deductible.

---

**Keep in Mind**

Copays do not count toward your annual deductible.

The network and out-of-network deductibles are independent of each other. Specifically, only network expenses are credited toward the network deductible and only out-of-network expenses are credited toward the out-of-network deductible.

Refer to the [Summary of Benefits](#) to see a comparison of network and out-of-network deductibles.

**Deductible Carryover**

The Plan uses the date of service for keeping track of which covered expenses get credited to the deductible for each calendar year, not the date you make the payment. Expenses incurred and credited toward your deductible during the last three (3) months of the calendar year can be carried over to the next calendar year and applied toward the deductible for that year, too.

**Coinsurance**

Once you meet your deductible, the Plan begins paying benefits for covered expenses. The portion paid by the Plan, generally 80% for network care, is the Plan’s coinsurance. When the Plan’s coinsurance is less than 100%, you pay the balance. The part you pay is called your coinsurance.

The Plan’s benefit levels for network and out-of-network care are different. Refer to the [Summary of Benefits](#) for more information.
An Example

Here is an example of how the deductible and coinsurance features apply when you use network services:

- Hospital room and board expense: $2,500
- Your annual network deductible: $525
- Your network coinsurance: 20%

Your share of the cost = deductible + your coinsurance amount

- Balance after deductible: $1,975 ($2,500 minus $525)
- Your coinsurance: $395 (20% of $1,975)
- Your cost: $920 ($525 + $395)
- Plan’s share of the cost: $1,580 ($2,500 minus $920)

Compare this example to the out-of-network example in Sharing the Cost of Out-of-Network Care to see how you can save by choosing network providers.

Out-of-Pocket Maximum

The Plan puts a limit on the amount you pay for certain covered expenses out of your own pocket each year, called the out-of-pocket maximum. The out-of-pocket maximum helps protect you financially when a catastrophic medical event occurs by putting a limit on how much you pay for deductible and coinsurance in a calendar year.

- The individual out-of-pocket maximum applies separately to each covered person in the family. Once a family member reaches the $2,625 individual out-of-pocket maximum for network care, the Plan pays 100% of that person’s covered network expenses for the rest of the calendar year.
- The family out-of-pocket maximum applies to the family as a group. When your family’s combined out-of-pocket expenses satisfy the $5,250 family out-of-pocket maximum for network care, the Plan pays 100% of the family’s covered network expenses for the remainder of the calendar year. All covered family members can contribute toward the family out-of-pocket maximum; however, not more than the individual out-of-pocket maximum per person will be credited to meet the family out-of-pocket maximum.

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

- Copayment amounts;
- Plan penalties;
- Expenses covered at 50%; and
- Charges for services and supplies that are not covered by the Plan.

Keep in Mind

After you reach the individual and/or family out-of-pocket maximum for a calendar year, you are still responsible for any office visit and emergency room copayments that apply.
The Plan has separate out-of-pocket maximums for network and out-of-network care:

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

**What Is Covered In-Network**

The [Summary of Benefits](#) gives you an outline of the services and supplies that are covered when given by a network provider, and shows you the benefit level that applies to each type of care. For more detail about covered expenses, refer to the [What the Plan Covers](#) chapter of this handbook.
OUT-OF-NETWORK BENEFITS

How Out-of-Network Benefits Work

When you need medical care, you have a choice. You can select a doctor or facility that belongs to the network (a network provider) or one that does not belong (an out-of-network provider).

If you use an out-of-network provider, you’ll pay more out of your own pocket for your care. You may be required to file your own claims and you must make the telephone call required for precertification. (See Claims and Appeals and Precertification for more information.)

The Summary of Benefits shows how the Plan’s level of coverage differs when you use network versus out-of-network providers. In most cases, you save money when you use network providers.

Sharing the Cost of Out-of-Network Care

You share in the cost of your medical care by paying deductibles, copays and coinsurance. The Summary of Benefits shows how these features apply to covered out-of-network medical services and supplies:

- For an emergency room visit to treat an emergency condition, you pay only a copay, then the Plan pays the remainder of the cost, up to the recognized charge. You are responsible for any expenses that exceed the recognized charge.
- Other services are subject to a deductible and coinsurance. The coinsurance method of payment requires that you pay 100% of all covered medical expenses for the year up to a specified amount called a deductible. Once you meet the deductible, the Plan will begin paying a percentage of the cost of covered expenses, up to the recognized charge. You are responsible for any expenses that exceed the recognized charge.

These terms are defined in the Glossary and discussed in more detail below.

Keep in Mind

The Plan covers network preventive care at 100%, with no deductible or copay. You save money when you choose network providers for preventive care.
**Copay (copayment)**

A **copay**, sometimes called a copayment, is a fee that you must pay at the time you receive some types of care. After your copay, the Plan will generally cover the remainder of the recognized charge.

A $135 copay applies to each emergency room (ER) visit to treat an **emergency condition**

---

**Keep in Mind**

A copay does not apply toward your deductible or out-of-pocket maximum.

---

**Deductible**

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

- **Individual:** The individual deductible applies separately to each covered person in the family. When a person’s out-of-network deductible expenses reach the $1,050 individual deductible for out-of-network care, the person’s out-of-network deductible is met. The Plan then starts to pay that person’s covered out-of-network expenses at the applicable coinsurance percentage.

- **Family:** The family deductible applies to the family as a group. When the combined out-of-network deductible expenses of all covered family members reach the $2,100 family deductible for out-of-network care, the family out-of-network deductible is met. The Plan then begins to pay benefits for covered out-of-network care for all covered family members. All covered family members can contribute toward the family deductible; however, not more than the individual deductible amount per person will be credited to meet the family deductible.

---

**Keep in Mind**

Copays, amounts above the **recognized charge**, plan penalties and reduced coinsurance do not count toward your annual deductible.

---

The network and out-of-network deductibles are independent of each other. Specifically, only network expenses are credited toward the network deductible and only out-of-network expenses are credited toward the out-of-network deductible.

Refer to the **Summary of Benefits** to see a comparison of network and out-of-network deductibles.

**Deductible Carryover**

The Plan uses the date of service for keeping track of which covered expenses get credited to the deductible for each calendar year, not the date you make the payment. Expenses incurred and credited toward your deductible during the last three (3) months of the calendar year may be carried over to the next calendar year and applied toward the deductible for that year, too.
**Coinsurance**

Once you meet your deductible, the Plan begins paying benefits for covered expenses. The portion paid by the Plan, generally 60% for out-of-network care, is the Plan’s coinsurance. When the Plan’s coinsurance is less than 100%, you pay the balance. The part you pay is called your coinsurance.

Refer to Retail Pharmacy for information about your costs for out-of-network prescription drugs.

The Plan has different coinsurance levels for network and out-of-network care for each type of covered expense. Refer to the Summary of Benefits for a comparison of network and out-of-network benefit levels.

**An Example**

Here is an example of how the deductible and coinsurance features apply when you use out-of-network services:

- Hospital room and board expense: $2,500
- Your annual out-of-network deductible: $1,050
- Your out-of-network coinsurance: 40%

Your share of the cost = deductible + your coinsurance amount

- Balance after deductible: $1,450 ($2,500 minus $1,050)
- Your coinsurance: $580 (40% of $1,450)
- Your cost: $1,630 ($1,050 + $580)
- Plan’s share of the cost: $870 ($2,500 minus $1,630)

Compare this example to the network example in Sharing the Cost of Network Care to see how you can save by choosing network providers.

**Out-of-Pocket Maximum**

The Plan puts a limit on the amount you pay for covered expenses out of your own pocket each year, called the out-of-pocket maximum. The out-of-pocket maximum helps protect you financially when a catastrophic medical event occurs by putting a limit on how much you pay for deductible and coinsurance in a calendar year.

- *The individual out-of-pocket maximum* applies separately to each covered person in the family. Once a family member reaches the $8,400 individual out-of-pocket maximum for out-of-network care, the Plan pays 100% of that person’s covered out-of-network medical expenses for the rest of the calendar year.

- *The family out-of-pocket maximum* applies to the family as a group. When your family’s combined out-of-pocket expenses satisfy the $16,800 family out-of-pocket maximum for out-of-network care, the Plan pays 100% of the family’s covered out-of-network medical charges for the remainder of the calendar year. All covered family members can contribute toward the family out-of-pocket maximum; however, not more than the individual out-of-pocket maximum per person will be credited to meet the family out-of-pocket maximum.
Certain expenses do **not** apply toward the out-of-pocket maximum:

- Copayment amounts;
- Expenses over the **recognized charge**;
- Plan penalties, including any additional out-of-pocket expenses you pay because you did not obtain the necessary precertification for a service; and
- Charges for services and supplies that are not covered by the Plan.

**Keep in Mind**

After you reach the individual and/or family out-of-pocket maximum for a calendar year, you are still responsible for any copayments and precertification penalties that apply.

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

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

Refer to the [Summary of Benefits](#) for more information.

**What Is Covered Out-of-Network**

The [Summary of Benefits](#) gives you an outline of the services and supplies that are covered when given by an out-of-network provider, and shows you the benefit level that applies to each type of care. For more detail about covered expenses, refer to the [What the Plan Covers](#) chapter of this handbook.
WHAT THE PLAN COVERS

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

The Plan contains various provisions that are intended to help AMETEK and you control medical costs. These provisions simply identify the benefits that the Plan is designed to pay. They are not restrictions on the course of treatment that a patient and his or her medical care provider may decide is appropriate or desirable. The patient and his or her provider are ultimately responsible for deciding on the course of treatment to be followed in any situation, regardless of whether it appears the Plan will pay for that care.

You Need to Know

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

The Plan covers only expenses related to non-occupational injury and non-occupational disease.

Preventive Care

A full list of the current recommendations for preventive care screenings can be found on the U.S. Preventive Services Task Force (USPSTF) website at http://www.ahrq.gov/clinic/uspstfix.htm. Vaccine schedules change often. The most current recommendations for vaccines can be found on the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/vaccines.

Preventive Physical Exams

The Plan covers charges for an annual routine physical exam, including (but not limited to):

- Blood pressure check;
- Blood cholesterol check;
- Thyroid function analysis;
- Complete blood check (CBC);
- Urinalysis; and
- Immunizations for infectious diseases and the materials needed to administer the immunizations.

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

If an exam is given to diagnose or treat a suspected or identified injury or disease, it is not considered a routine physical exam.
Coverage of routine physical exams is subject to the following limits:

- Adults and children age 18 and over – one exam per calendar year
- Children under age 18:
  - 1st 12 months: 7 exams
  - 13-24 months: 3 exams
  - 25-36 months: 3 exams
  - age 3-18: 1 exam per calendar year

**Preventive Ob/Gyn Exams**

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

**Screening and Counseling Services**

The Plan covers the following services provided by your primary care physician in an individual or group setting:

- Obesity: screening and counseling services to help you lose weight if you are obese. Coverage includes:
  - Preventive counseling visits;
  - Medical nutrition therapy;
  - Nutritional counseling; and
  - Healthy diet counseling visits provided in connection with high cholesterol and other known risk factors for cardiovascular and diet-related chronic disease.

The following limits apply to screening and counseling services for obesity:

- up to age 22: unlimited visits
- age 22 and over: up to 26 visits per calendar year (healthy diet counseling limited to 10 visits)

- Use of tobacco products: screening and counseling services to help you stop using tobacco products. Coverage includes:
  - Preventive counseling visits;
  - Treatment visits; and
  - Class visits.

The Plan covers up to 8 counseling sessions per calendar year.

- Misuse of alcohol and/or drugs: screening and counseling services to help prevent or reduce the use of alcohol or controlled substances. Coverage includes:
  - Preventive counseling visits;
  - Risk factor reduction intervention; and
  - A structured assessment.

The Plan covers up to 5 visits per calendar year.
The Plan’s preventive care coverage includes the following services for women:

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

**Keep in Mind**

The Plan’s preventive screening and counseling services do not include psychiatric, psychological, personality or emotional testing or exams.

**Preventive Cancer Screenings**

The Plan covers:

- One preventive baseline mammogram for women age 35 to 39, and one preventive mammogram each calendar year for women age 40 and over; and
- One digital rectal exam (DRE) and prostate specific antigen (PSA) test per calendar year for men age 40 and over.
- Beginning at age 50, the Plan covers the following tests when recommended by your physician:
  - One fecal occult blood stool test per calendar year.
  - For those at average risk for colorectal cancer:
    - One colonoscopy every 10 years; or
    - One sigmoidoscopy every 5 years; or
    - One double contrast barium enema every 5 years.

**Vision Services**

**Preventive Eye Exams**

The Plan covers charges for routine eye exams, which may be performed by an ophthalmologist or optometrist. Coverage is limited to one exam per calendar year.
Office Visits and Walk-In Clinics

Office Visits

The Plan covers treatment by a doctor in his or her office. Coverage includes:

- Allergy testing and treatment;
- Dermatology treatment;
- Immunizations for infectious disease; and
- Supplies, radiology services, X-rays and tests given by the physician.

Keep in Mind

You pay the office visit copay for a network office visit. Related lab work and testing that is done as part of the visit or ordered by your physician as a result of the visit are subject to the applicable deductible and/or coinsurance.

Walk-In Clinics

A walk-in clinic is a free-standing health care facility. The Plan covers visits to walk-in clinics for non-emergency treatment of an illness or injury, and for administration of certain immunizations. Walk-in clinics are not an alternative to emergency room services in a true emergency. However, there are circumstances when walk-in clinics are appropriate.

Keep in Mind

The Plan’s benefits for outpatient care that you receive from a network provider will be based on whether the provider is affiliated with, or bills through, a hospital or similar facility (such as a clinic). The outpatient services of a provider that is part of a hospital or similar facility are subject to the Plan’s deductible and coinsurance.

Family Planning and Maternity

Voluntary Sterilization

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

Contraception Services

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

- Contraceptive counseling.
- Contraceptive devices prescribed by a physician.
AMETEK, Inc. High PPO Option

- Office visit for the injection of injectable contraceptives.
- Related outpatient services such as consultations, exams and procedures.

Refer to the Prescription Drug Program chapter of this handbook for more information about coverage for prescription drugs.

Infertility Services

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

- The female partner has a condition that:
  - Is a demonstrated cause of infertility; and
  - Has been recognized by a gynecologist or infertility specialist; and
  - Is not caused by voluntary sterilization or a hysterectomy; or

- The male partner has a condition that:
  - Is a demonstrated cause of infertility; and
  - Has been recognized by a urologist or infertility specialist; and
  - Is not caused by voluntary sterilization and/or a vasectomy.

- The procedures are performed on an outpatient basis.
- Follicle-stimulating hormone (FSH) levels are less than 19 mIU/ml on day 3 of the menstrual cycle.
- The woman can’t become pregnant through less costly treatment that is covered by the Plan.

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

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

Infertility Service Exclusions

The Plan does not cover:

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

**Maternity Care**

**Keep in Mind**

A newborn is considered to be a new participant in the Plan. You must enroll the child within 90 days of birth. The child will be covered retroactively to the day of birth if enrolled within this 90-day period. If you do not enroll the child within 90 days, the child will not be covered by the Plan for the remainder of the Plan year. You can enroll the child for the next Plan year during the annual enrollment period.

The Plan covers the following services related to maternity:

• Prenatal care (the office visit copay is waived for routine prenatal visits to a network physician after the first visit);
• Hospital and physician care for the mother and enrolled newborn;
• Delivery room;
• Recovery room; and
• Newborn nursery care.

In accordance with the Newborns’ and Mothers’ Health Protection Act, the Plan covers inpatient care of the mother and newborn child for a minimum of:

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

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

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

- Ultrasounds, except when medically necessary;
- Amniocentesis solely for the purpose of determining the sex of the unborn child; or
- Home births. This is childbirth that takes place outside a hospital or birthing center, or in a place that is not licensed to perform deliveries.

**Newborn Care**

The Plan covers hospital and physician care for a newborn child who is enrolled in the Plan. A separate deductible and out-of-pocket maximum apply to the newborn’s expenses.

Use the online Benefits Administration System at [www.portal.adp.com](http://www.portal.adp.com) or call the AMETEK Benefits Service Center at 1-888-263-8351 (select option 1) to enroll your newborn in the Plan within 90 days of his or her birth. For information about eligibility and enrollment, refer to the **AMETEK, Inc. Health and Welfare Plan Overview** booklet.

**Birthing Center**

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

**Breast Feeding Support, Counseling and Supplies**

The Plan covers:

- Breast feeding assistance, training and counseling services by a certified lactation support provider in a group or individual setting. The office visit copay is waived for up to 6 visits to a network provider per calendar year.
- Purchase of a standard (not hospital-grade) electric breast pump, if you have not purchased either a standard electric or a manual pump within the past three years. The pump must be purchased within 60 days from the date of your child’s birth.
- Purchase of a manual breast pump, if you have not purchased either a standard electric or a manual pump within the past three years. The pump must be purchased within 12 months from the date of your child’s birth.
- Purchase of the accessories needed to operate the breast pump.

If you use a breast pump from a prior pregnancy, the Plan covers the purchase of a new set of breast pump supplies within the first 12 months following the birth of your child.
Hospital Care

**Need Help With a Serious Health Condition?**

When a serious illness or injury occurs, Aetna offers resources to help you understand the condition and navigate the health care system. See [Care Management](#) for more information.

The Plan covers charges made by a hospital for room and board when you are confined as an inpatient. Room and board charges are covered up to the hospital’s semi-private room rate. If a hospital does not itemize room and board charges, as well as other charges, Aetna will assume that 40 percent of the total is for room and board and 60 percent is for other charges.

**Remember!** Precertification is required for inpatient hospital care.

**Keep in Mind**

The Plan does not cover private room charges that exceed the hospital’s semi-private room rate unless a private room is medically necessary because of a contagious illness or immune system problems.

The Plan also covers other services and supplies provided during your inpatient stay, such as:

- Services of a physician, surgeon, radiologist and anesthesiologist;
- Operating and recovery rooms;
- Intensive or special care facilities;
- Administration of blood and blood products;
- Radiation therapy;
- Physical, occupational and speech therapy;
- Oxygen and oxygen therapy;
- X-rays, laboratory tests and diagnostic services;
- Medications;
- Intravenous (IV) preparations; and
- Discharge planning.

**Keep in Mind**

Physicians and other providers may bill you separately for services given in the outpatient department of a hospital or a surgery center, or during your hospital stay. In most cases, if you receive services from a provider who is not in the Aetna network (an out-of-network provider), the Plan will cover those services at the out-of-network benefit level, even if the facility is a network facility.

Services provided by a radiologist, anesthesiologist or pathologist that is not in the Aetna network, however, are covered at the network benefit level, as long as the treating physician (your doctor or surgeon) and the facility are network providers.
Surgery
The Plan covers the charges made by a physician for:

- Performing your surgical procedure.
- Pre-operative and post-operative visits.
  Note: Pre-operative and post-operative visits by your surgeon are considered to be part of the surgical fee. The Plan does not cover separate fees for pre-operative and post-operative care.
- Radiology and pathology services.
- Consultation with another physician to obtain a second opinion prior to the surgery. Whatever the second physician recommends, it is your decision whether or not you have the surgery. If the second physician’s opinion is different from the initial physician’s opinion, you can get a third opinion by following the same process as you did in getting the second opinion.

If you need to have multiple surgical procedures done at the same time or during a single operating session:

- The Plan normally pays a lower percentage of the fees that are charged for the secondary procedure(s).
- The Plan does not cover any surgery that is not medically necessary, even if performed with another procedure that is necessary.

Keep in Mind
Surgery performed by a physician who is not in the Aetna network will be covered as out-of-network care and subject to recognized charge limits . . . even if the surgery is performed in a network hospital.

Acupuncture
The Plan covers acupuncture services given by a physician in lieu of anesthesia in connection with a covered surgical procedure.

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

The Plan covers inpatient or outpatient charges made by a hospital or a physician for the medically necessary surgical treatment of morbid obesity. Bariatric surgery must be approved in advance by Aetna.

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

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**Keep in Mind**

The Plan does not cover bariatric surgery when done for cosmetic reasons.

Refer to Aetna’s Clinical Policy Bulletins to learn more about coverage for weight loss surgery. You can find the CPBs at [www.aetna.com](http://www.aetna.com).

**Oral Surgery**

The Plan covers oral surgery and treatment of accidental injury to natural teeth:

- Hospital services and supplies received for an inpatient hospital confinement required because of your condition.
- Services of a physician or dentist for treatment of the following conditions of the teeth, mouth, jaws, jaw joints or supporting tissues if medically necessary:
  - Surgery necessary to treat a fracture, dislocation or wound;
  - Surgery necessary to alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot improve function;
  - Surgery necessary to cut out
    - teeth partly or completely impacted in the bone of the jaw;
    - teeth that will not erupt through the gum;
    - other teeth that cannot be removed without cutting into bone;
    - the roots of a tooth without removing the entire tooth; or
    - cysts, tumors or other diseased tissues;
  - Surgery to cut into gums and tissues of the mouth, as long as this is not done in connection with the removal, replacement or repair of teeth; and
  - Non-surgical treatment of infections or diseases not related to the teeth.
- Treatment of accidental injury to sound natural teeth or tissues of the mouth. The treatment must occur within the calendar year of the accident, or in the following calendar year. The teeth must have been free from decay or in good repair, and firmly attached to the jaw bone at the time of the injury.
The Plan’s coverage of dentures, bridgework, crowns and appliances is limited to:
- The first denture or fixed bridgework to replace teeth that were lost as the result of accidental injury;
- The first crown (cap) needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

**Coordination With the Company Dental Plan**

Certain oral surgery that involves the teeth is considered “dental in nature.” The Company’s dental plan is primary for oral surgery that is dental in nature, with the exception of removing impacted teeth. This means that the dental plan considers the claim for payment first. After the dental claim has been processed, you can submit a medical claim for oral surgery expenses that are not covered by the dental plan. Your claim must include a copy of the dental Explanation of Benefits.

Except as described above to treat accidental injury, the Plan does not cover charges:
- For dental implants;
- For in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of those services or supplies is to relieve pain;
- For root canal therapy;
- To remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- To repair, replace or restore fillings, crowns, dentures or bridgework;
- For non-surgical periodontal treatment;
- For dental cleaning, in-mouth scaling, planing or scraping; or
- For myofunctional therapy. This is muscle training therapy or training to correct or control harmful habits.

**Outpatient Surgery**

The Plan covers outpatient surgery in:
- The office of a physician or dentist;
- A surgery center; or
- The outpatient department of a hospital.

The Plan covers the following outpatient surgery expenses:
- Services and supplies provided on the day of the procedure;
- The operating physician’s services for performing the procedure, related pre- and post-operative care and the administration of anesthesia; and
- Services of another physician for related post-operative care and the administration of anesthesia (other than a local anesthetic).
The Plan does not cover the services of a physician who renders technical assistance to the operating physician.

**Reminder**
It’s important to use network providers to keep your share of the cost as low as possible. Before you have outpatient surgery, make sure that the facility is in the network. Surgery done in an out-of-network facility will be covered as out-of-network care … even if the surgery was ordered or performed by a network physician.

**Pre-Admission Testing**
The Plan covers outpatient testing done by a hospital, surgery center, physician or licensed diagnostic lab before a covered surgical procedure. The tests must be:
- Related to surgery that will take place in a hospital or surgery center;
- Completed within 14 days of your surgery;
- Performed on an outpatient basis;
- Covered if you were confined in a hospital; and
- Included in your medical record kept by the hospital or surgery center where the surgery takes place.

**Keep in Mind**
If your tests indicate that surgery should not be performed because of your physical condition, the Plan covers the tests, but not the proposed surgery.

**Reconstructive Surgery**
The Plan covers reconstructive and cosmetic surgery if the surgery is needed:
- To repair an accidental injury that happens while you are covered by the Plan. The surgery must be performed in the calendar year of the accident or the following calendar year. This time period may be extended for a child through age 18.
- To correct a severe anatomical defect present at birth (or appearing after birth) if:
  - The defect has caused severe facial disfigurement or significant functional impairment; and
  - The purpose of the surgery is to improve function.
- To improve function when the treatment of an illness has resulted in severe facial disfigurement or significant functional impairment of a body part.
- As part of reconstruction following a mastectomy.

To learn more about coverage for reconstructive surgery, refer to Aetna’s Clinical Policy Bulletins at [www.aetna.com](http://www.aetna.com).
**Transplants**

**If You Need a Transplant**

Call the Integrated Aetna Service Center at **1-888-263-8351** (select option 2) when you and your physician begin to discuss transplant services. A service specialist can answer benefit questions, help you find a network provider, tell you about the services offered by the National Medical Excellence Program and refer you to the Special Case Customer Service Unit to start the transplant authorization process.

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

- Pre-transplant evaluation and screening. This phase includes evaluation and acceptance into a transplant facility’s transplant program.
- Pre-transplant candidacy screening. This phase includes compatibility testing of prospective organ donors who are immediate family members.
- Transplant event. This phase includes organ procurement, surgical procedures and medical therapies related to the transplant.
- Follow-up care. During this phase, you may need home health care services, home infusion services and other outpatient care.

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

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

The Plan covers:

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

- Services and supplies provided to a donor when the recipient is not covered by this Plan;
- Outpatient drugs, including biomedicals and immunosuppressants, that are not expressly related to an outpatient transplant occurrence;
- Home infusion therapy after the transplant coverage period ends;
- Harvesting or storage of organs without the expectation of an immediate transplant for an existing illness; or
- Harvesting or storage of bone marrow, tissue or stem cells without the expectation of a transplant to treat an existing illness within 12 months.

**If You Need a Transplant or Other Complex Medical Care**

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

**The Institutes of Excellence™ Network**

Through the Institutes of Excellence™ (IOE) network, you have access to a provider network that specializes in transplants. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes. Through the IOE Program, you can receive care for the following transplants:

- Bone marrow
- Heart
- Heart and lung
- Kidney
- Kidney and pancreas
- Liver
- Lung
- Pancreas

If your physician recommends a transplant not included in the list above, contact the Integrated Aetna Service Center at 1-888-263-8351 (select option 2).

**Keep in Mind**

The Plan covers the transplants listed above at the network level of benefits only when performed at an IOE facility. These transplants will be covered as out-of-network care when performed at a non-IOE facility, even if the facility is considered a network facility for other types of care.

You can find a list of IOE facilities on DocFind, Aetna’s online provider directory, at www.aetna.com.
Alternatives to Hospital Inpatient Care

**Skilled Nursing Facility**

*Remember!* Precertification is required for skilled nursing facility care.

The Plan covers charges made by a skilled nursing facility during an inpatient stay, up to 60 days per calendar year, including:

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

**Keep in Mind**

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

**Home Health Care**

*Remember!* Precertification is required for home health care.

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

- Part-time nursing care that requires the medical training of, and is given by, an RN or by an LPN if an RN is not available. The services must be provided during intermittent visits of four hours or less.
- Part-time home health aide services, when provided in conjunction with, and in direct support of, care by an RN or LPN. The services must be provided during intermittent visits of four hours or less.
- Medical social services by a qualified social worker, when provided in conjunction with, and in direct support of, care by an RN or LPN.
- Medical supplies, prescription drugs and lab services given by (or for) a home health care agency. Coverage is limited to what would have been covered if you had remained in a hospital.

Physical, speech and occupational therapy given as part of a home health care plan are subject to the maximum for short-term rehabilitation described in [Short-Term Rehabilitation](#).

**Keep in Mind**

The Plan does not cover custodial care, even if the care is provided by a nursing professional, and family members or other caretakers cannot provide the necessary care.
Hospice Care

**Remember!** Precertification is required for hospice care.

The Plan covers hospice care for a person who is terminally ill. The services of a network provider are covered at 100%, and the annual deductible is waived (the Plan covers out-of-network services at 60% after the annual out-of-network deductible is met). The Plan covers:

- Charges made by a hospice facility, hospital or skilled nursing facility for:
  - Room and board and other services and supplies provided 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.
- Charges made by a hospice care agency for:
  - Part-time or intermittent nursing care by an RN or LPN for up to eight hours in a day.
  - Part-time or intermittent home health aide services for up to eight hours in a day. These services consist mainly of caring for the patient.
  - Medical social services under a physician’s direction.
  - Psychological and dietary counseling.
  - Consultation or case management services provided by a physician.
  - Physical and occupational therapy.
  - Medical supplies.
- Charges made by providers who are not employed by the hospice care agency, as long as the agency retains responsibility for your care:
  - A physician for consultation or case management.
  - A physical or occupational therapist.
  - A home health care agency for:
    - Physical and occupational therapy.
    - Part-time or intermittent home health aide services for up to eight hours in any one day.
    - Medical supplies.
    - Psychological or dietary counseling.

**Support During the Advanced Stages of an Illness**

The Aetna Compassionate CareSM Program offers support and services to those facing the advanced stages of an illness. Refer to Advanced Illness Resources for more information.
The Plan’s hospice care benefit does not include coverage for:

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

**Private Duty Nursing**

*Remember!* Precertification is required for private duty nursing care.

The Plan covers charges made by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for private duty nursing if a person’s condition requires skilled nursing services and visiting nursing care is not enough.

The Plan covers up to a maximum of 45 private duty nursing shifts per calendar year. A “shift” consists of up to 8 hours of skilled nursing care.

The Plan also covers skilled observation following:

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

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

The Plan does **not** cover:

- Any care that does not require the education, training and technical skills of an RN or LPN. This would include transportation, meal preparation, charting of vital signs and companionship activities.
- Any private duty nursing care provided on an inpatient basis.
- Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting.
- Nursing care that consists only of skilled observation, except as described above.
- Any service provided only to administer oral medicines, except where the law requires medication to be administered by an RN or LPN.
Emergency and Urgent Care

Emergency Care

The Plan covers emergency care provided in a hospital emergency room or a free-standing emergency facility. The care must be for an emergency condition.

What Is an Emergency Condition?

An emergency condition is a recent and severe medical condition – including (but not limited to) severe pain – that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that your condition, sickness or injury is of such a nature that failure to get immediate medical care could result in placing your health in serious jeopardy, serious impairment to bodily function, serious dysfunction of a body part or organ, or serious jeopardy to the health of the fetus (in the case of a pregnant woman).

The emergency care benefit covers:

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

If you are admitted to the hospital following emergency room treatment, remember that hospital admissions must be precertified (see Precertification for details).

Keep in Mind

The Plan pays a reduced benefit (50% after your annual deductible is met) for non-emergency care given in a hospital emergency room.

What Should I Do In An Emergency?

Whenever you are in need of urgent or emergency medical care, call 911 or seek treatment immediately at the nearest emergency department or urgent care facility. You should also contact your physician, even after hours, within 48 hours after the commencement of care.

You, your physician or a family member should also call the Integrated Aetna Service Center at 1-888-263-8351 (select option 2) within 48 hours if you are admitted to the hospital as the result of an emergency condition.

All services for emergency and urgent care are subject to review by Aetna after delivery of the care. Your benefits may be reduced or the Plan may not cover your care if Aetna determines that an emergency or urgent condition did not exist.

Ambulance services for a non-emergency must be approved by Aetna in advance.

You are covered for emergencies anywhere in the world. To receive network-level benefits, you should notify Aetna within 48 hours or as soon as possible if you are admitted to the hospital.
Keep in Mind
An employee who needs emergency or urgent medical care while traveling outside the United States on Company business is covered by the Aetna WorldTravelerSM Program. For more information, call Aetna’s International Member Service Center at the toll-free telephone number shown on the back of your AGB WorldTraveler ID card or visit www.aetnaglobalbenefits.com.

Urgent Care
The Plan covers the services of a hospital or urgent care provider to evaluate and treat an urgent condition. Urgent care providers are physician-staffed facilities offering unscheduled medical services.

What Is an Urgent Condition?
An urgent condition is a sudden illness, injury or condition that is severe enough to require prompt medical attention to avoid serious health problems, including a condition that could cause you severe pain that cannot be managed without urgent care or treatment. An urgent condition does not require the level of care provided in a hospital emergency room, but does require immediate outpatient medical care that can’t be postponed until your physician becomes reasonably available.

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

Keep in Mind
The Plan does not cover non-urgent care given by an urgent care provider.

Ambulance
The Plan covers charges made for a professional ambulance. The conditions for coverage vary with the type of vehicle used:

Ground Ambulance
The Plan covers:
- Transportation in a medical emergency to the nearest facility that can treat you;
- Transportation in a medical emergency from one hospital to another hospital when the first hospital does not have the required services or facilities for your condition;
• Transportation from hospital to home or to another facility when an ambulance is medically necessary for safe and adequate transport; and

• Transportation while confined in a hospital or skilled nursing facility to receive medically necessary inpatient or outpatient treatment when an ambulance is required for safe and adequate transport.

**Air or Water Ambulance**

The Plan covers transport to a hospital by air or water ambulance when:

• Ground ambulance is not available; and

• Your condition is unstable and requires medical supervision and rapid transport.

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

• The first hospital does not have the required services or facilities for your condition; and

• Ground ambulance is not available; and

• Your condition is unstable and requires medical supervision and rapid transport.

**Other Covered Expenses**

This section describes other covered expenses for both inpatient and outpatient care.

**Chemotherapy**

Coverage for chemotherapy depends on where you receive treatment:

• In most cases, chemotherapy is covered as outpatient care.

• The Plan covers the initial dose of chemotherapy given in the hospital when:
  – You have been hospitalized for the diagnosis of cancer; and
  – A hospital stay is necessary based on your health status.

**Chiropractic Care**

The Plan covers manipulative treatment of a condition caused by (or related to) biomechanical or nerve conduction disorders of the spine. Care must be given by a physician or licensed chiropractor in the provider’s office. Treatment of scoliosis, of a fracture, or before or after surgery is not covered as a spinal manipulation benefit.

The services of a chiropractor are limited to 30 visits per calendar year.

**Complex Imaging**

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

• Computerized axial tomography (CAT) scans;

• Magnetic resonance imaging (MRI); and

• Positron emission tomography (PET) scans.
**Diagnostic X-Ray and Laboratory (DXL) Procedures**

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

It’s important to use network providers to keep your share of the cost as low as possible. Before going to an outpatient facility for diagnostic tests, make sure that the facility is in the network. Tests done by an out-of-network facility will be covered as out-of-network care ... **even if your tests were ordered by a network physician.**

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**Keep in Mind**

In general, complex imaging, diagnostic X-rays and lab tests cost less if you use an independent laboratory or radiology center instead of a hospital’s outpatient department.

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**Durable Medical and Surgical Equipment**

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

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

- It either can’t be rented or would cost less to purchase than to rent; and
- Long-term use is planned.

The Plan also covers the repair of this equipment when necessary. Maintenance and repairs needed because of misuse or abuse of the equipment are not covered.

Replacement is covered if you show Aetna that the repair 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.

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**Reminder**

It’s important to use network providers to keep your share of the cost as low as possible. Before you rent or purchase durable medical equipment, make sure that the provider is in the network.

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**Experimental or Investigational Services**

In general, the Plan does not cover drugs, devices, treatments or procedures that are experimental or investigational. There are, however, some situations where the Plan will cover a drug, device, treatment or procedure that would otherwise be considered experimental or investigational.

The Plan will cover care that is considered experimental or investigational if the care meets all the following conditions:

- You have been diagnosed with cancer or a condition likely to cause death within one year;
- Standard therapies have not been effective or are inappropriate;
• Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;

• You are enrolled in a clinical trial that meets these criteria:
  – The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  – The clinical trial has passed independent scientific scrutiny and has been approved by an institutional review board that will oversee the investigation;
  – The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the U.S. Food and Drug Administration or the Department of Defense) and conforms to NCI standards;
  – The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
  – You are treated in accordance with protocol.

**Approval Required**

You must get approval from Aetna before receiving experimental or investigational care.

**Prosthetic Devices**

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

Here are some examples of covered devices:

• An artificial arm, leg, hip, knee or eye.
• An eye lens.
• An external breast prosthesis and the first bra made solely for use with the prosthesis after a mastectomy.
• One wig or hairpiece every three years, up to a maximum covered amount of $200. The wig or hairpiece must be prescribed by a physician for a covered condition causing hair loss and resulting from illness, treatment of illness or accidental injury. These conditions include, but are not limited to:
  – chemotherapy;
  – radiation therapy;
  – alopecia areata;
  – endocrine, metabolic or psychological disorders; and
  – severe burns or other injuries.
• A breast implant after a mastectomy.
• A cardiac pacemaker.
Coverage includes:

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

Radiation Therapy

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

Short-Term Rehabilitation

Physical, Occupational and Speech Therapy

The Plan covers short-term, outpatient rehabilitation therapy to improve a body function lost as the result of an illness or injury. The treatment must be:

- Part of a treatment plan;
- Provided by a physician or a licensed or certified physical, occupational or speech therapist;
- Expected to result in significant improvement of the condition within 60 days of the start of treatment.

Covered expenses include services for:

- Physical therapy expected to significantly improve, develop or restore physical functions that were lost or impaired because of an acute illness, injury or surgical procedure.
  
  Physical therapy does not include educational training or services designed to develop physical function.

- Occupational therapy expected to:
  - Significantly improve, develop or restore physical functions lost or impaired because of an acute illness, injury or surgical procedure; or
  - Re-teach skills to improve independence in the activities of daily living.

  Occupational therapy does not include educational training or services designed to develop physical function.

- Speech therapy:
  - To restore the loss of speech function or correct a speech impairment resulting from disease or injury; or
  - To treat delays in the development of speech function that are the result of a gross anatomical defect present at birth (for example, a cleft palate or a cleft lip).
Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing thoughts with spoken words.

The Plan limits benefits for all rehabilitation therapy to a maximum of 60 visits per calendar year.

*Call Your Provider Before Starting Therapy*

The Plan’s benefits for short-term rehabilitation services that you receive from a network provider on an outpatient basis will be based on whether the provider is affiliated with, or bills through, a hospital or similar facility (such as a clinic):

- The services of a provider that is part of a hospital or similar facility are subject to the Plan’s deductible and coinsurance.
- The outpatient services of network providers not affiliated with a hospital or similar facility are generally covered at 100% after you pay a copay.

When you need short-term rehabilitation services, it’s helpful to know in advance whether a copay or the deductible and coinsurance will apply. If you’ll be getting the therapy in the outpatient department of a hospital, the Plan’s deductible and coinsurance will apply. For other providers, call the provider before starting the therapy and ask if they are part of a hospital.

- If the answer is “yes,” the deductible and coinsurance will likely apply.
- If the answer is “no,” ask if a hospital does the billing for their services. If the answer is “yes, the deductible and coinsurance will likely apply.

You can also call the Integrated Aetna Service Center at **1-888-263-8351** (select option 2) and ask whether a visit to the provider will be subject to the applicable office visit copay.

*What Is Not Covered as Outpatient Short-Term Rehabilitation*

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or from congenital defects that are amenable to surgical repair. Therapies to treat pervasive developmental disorders (including autism), Down syndrome and cerebral palsy, for example, are not covered because these conditions are both developmental and/or chronic.
- Care provided by a family member.
- Treatment for delays in speech development not resulting from disease, injury or congenital defect.
- Special education to teach someone who has lost the ability to speak how to function without speech, including sign language lessons.

*To Learn More*

Go to Aetna’s Clinical Policy Bulletins, found at [www.aetna.com](http://www.aetna.com), for more information about physical, occupational and speech therapy.
Temporomandibular Joint Dysfunction (TMJ) Disorder
The Plan covers medical-in-nature treatment of TMJ disorder, including exams, X-rays, injections, anesthetics, physical therapy and oral surgery. The Plan does not cover appliances used to treat TMJ disorder, or procedures and/or restoration services that would have been necessary in the absence of the TMJ disorder.

Before TMJ Treatment
Claims for surgical treatment of TMJ disorder must be approved by an Aetna Medical Director. You are encouraged to contact the Integrated Aetna Service Center before the surgery is performed. The Medical Director will review your proposed treatment, and Aetna will let you know what benefits will be paid by the Plan based on the information provided. You and your physician can then decide how to proceed.

The advance review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid to help you make an informed decision about your care.

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

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

Other provisions of this law:
- The level of benefits for any portion of the hospital stay that extends beyond 48 hours (or 96 hours) cannot be less favorable to the mother or newborn than the earlier portion of the stay.
- The Plan cannot require precertification for a stay of up to 48 or 96 hours, as described above – although stays beyond those times must be precertified; see Precertification for details.
The Women’s Health and Cancer Rights Act

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

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

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

For answers to questions about the Plan’s coverage of mastectomies and reconstructive surgery, call the Integrated Aetna Service Center at 1-888-263-8351 (select option 2).
BEHAVIORAL HEALTH CARE

The Plan includes coverage for behavioral health care. You receive a higher level of benefits for inpatient and outpatient mental health and substance abuse treatment that is given by a behavioral health provider in the Aetna Behavioral Health network. Out-of-network care is covered, too, but at a lower level of benefits. Refer to the Summary of Benefits for a comparison of network and out-of-network behavioral health care benefits.

To be covered by the Plan, the care must be for:

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

Keep in Mind

Certain types of care must be precertified. See Precertification for more information.

Inpatient Care

The Plan covers inpatient services in a hospital, psychiatric hospital or residential treatment center when your condition requires services that are available only in an inpatient setting. Coverage includes:

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

Outpatient Treatment

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

Partial Confinement

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

Care is covered only if the condition requires treatment that is available only in a partial confinement treatment setting or if you would need inpatient care if you were not participating in this type of program.
Behavioral Health Exclusions

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

- Administrative psychiatric services when these are the only services rendered.
- Applied behavioral analysis (the LEAP, TEACCH, Denver or Rutgers programs).
- Bereavement counseling.
- Biofeedback.
- Confrontation therapy.
- Consultations with a mental health professional for adjudication of marital, child support and custody cases.
- Court-mandated or legally mandated treatment that is not considered **necessary**, as determined by Aetna, or that would not otherwise be covered by the Plan.
- Ecological or environmental medicine, diagnosis or treatment.
- Educational evaluation/remediation therapy or school consultations.
- Erhard Seminar Training (EST) or similar motivational services.
- Expressive therapies (art, poetry, movement, psychodrama).
- Hypnosis and hypnotherapy.
- Lovaas therapy.
- Marriage, family, child, career, social adjustment, religious, pastoral or financial counseling.
- Mental and psychoneurotic disorders not listed in the International Classification of Diseases, Ninth Revision (ICD-9).
- Mental health treatment for weight reduction or control.
- Primal therapy.
- Psychological counseling related to changing sex or sexual characteristics.
- Psychodrama.
- Stand-by services required by a physician.
- Telephone consultations.
- Transcendental meditation.
- Therapies for the treatment of delays in development, unless resulting from acute illness or injury. For example, the Plan does not cover treatment for the following diagnoses, because they are considered both developmental and/or chronic in nature:
  - Pervasive developmental disorders (including autism).
  - Down syndrome.
  - Cerebral palsy.
- Treatment of antisocial personality disorder.
• Treatment of impulse control disorders such as:
  – Caffeine or nicotine use;
  – Kleptomania;
  – Pathological gambling; or
  – Pedophilia.
• Treatment of health care providers who specialize in mental health and receive treatment as part of their training in that field.
• Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or to medical treatment for someone who is mentally incapacitated.
• Treatment of sexual addiction, co-dependency or any other behavior that does not have a DSM-IV diagnosis.
• Wilderness programs.
PRESCRIPTION DRUG PROGRAM

Coverage for prescription drugs is an important part of your health care coverage. The prescription drug program covers prescription drugs that are to be taken on an outpatient basis. Drugs that you need while you are confined in a hospital or other covered health care facility may be covered as part of your inpatient benefit – refer to the sections of this handbook that describe inpatient benefits for more information.

You have three ways to fill a prescription:

- At a retail pharmacy;
- By mail order, through Aetna Rx Home Delivery; or
- Through Aetna Specialty Pharmacy.

Three Copay Levels

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

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

Refer to Retail Pharmacy and the Summary of Benefits for information about the copay that applies to each tier of the prescription drug program:

- Tier I – most generic drugs
- Tier II – drugs that are on the Preferred Drug List
- Tier III – all other drugs

Generic and Brand-Name Drugs

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

Keep in Mind

If you choose a brand-name drug when a generic drug is available, you will be responsible for the applicable copay, plus the difference between the cost of the brand-name drug and the cost of the generic drug.
The Preferred Drug List

The Preferred Drug List, which is also known as Aetna’s formulary, shows the generic and brand name drugs that are considered preferred drugs. The drugs on the list are preferred because of their overall ability to meet members’ needs at a reasonable cost. You can reduce your copayment by using a covered generic drug (Tier I) or a covered brand-name drug that appears on the Preferred Drug List (Tier II). Your copayment will be highest if your physician prescribes a covered drug that does not appear on the Preferred Drug List (Tier III).

You can find Aetna’s Preferred Drug List online at www.aetnapharmacy.com. You can also call the Integrated Aetna Service Center at 1-888-263-8351 (select option 2) to request a printed copy of the List without charge.

Retail Pharmacy

Network Pharmacy

You may fill your prescription for up to a 30-day supply at a pharmacy that belongs to Aetna’s pharmacy network. Show your ID card and pay the applicable copayment at the time of your purchase:

- Tier I – $10 for most generic drugs, except generic contraceptives
- Tier II – $30 for drugs on the preferred drug list
- Tier III – $50 for other drugs

There are no claim forms to fill out.

You can find a list of network pharmacies using DocFind at www.aetna.com. You can also call the Integrated Aetna Service Center at 1-888-263-8351 (select option 2) for help finding a network pharmacy in your area.

Out-of-Network Pharmacy

You also may fill prescriptions at out-of-network pharmacies. The Plan pays 60% of the reasonable charge for covered drugs you purchase out-of-network, after the applicable copay:

- Tier I – $10 for most generic drugs, except generic contraceptives
- Tier II – $30 for drugs on the preferred drug list
- Tier III – $50 for other drugs

You are responsible for the balance.

You must file a claim for reimbursement for drugs purchased at an out-of-network pharmacy. See the chapter of this book entitled Claims and Appeals for more information.
Mail Order Prescriptions – Aetna Rx Home Delivery

If you take medications on a regular basis for a chronic (ongoing) condition (such as high blood pressure, asthma, allergies or diabetes), 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 with an order form and a check, money order or credit card number for the applicable copayment or coinsurance to Aetna:

- Tier I – $20 for most generic drugs, except generic contraceptives
- Tier II – $60 for drugs on the preferred drug list
- Tier III – $100 for other drugs

Order forms are available online at [www.aetnaxhomedelivery.com](http://www.aetnaxhomedelivery.com). You can also call the Integrated Aetna Service Center at 1-888-263-8351 (select option 2) for forms.

Refills are simple, too. When you receive your original prescribed medication from the mail service program, you will also receive refill information. You can order refills by mail, by phone or online at [www.aetnaxhomedelivery.com](http://www.aetnaxhomedelivery.com).

Specialty Pharmacy

Patients with chronic medical conditions often need medications that are not readily available at a local pharmacy. These medications may require special storage and handling, and sometimes they have side effects that must be carefully monitored.

Aetna Specialty Pharmacy provides convenient home delivery of up to a 30-day supply of specialty medications, including injectables and certain other drugs for patients with chronic medical conditions such as:

- Asthma
- Blood disorders
- Cancer
- Chronic renal failure
- Cystic fibrosis
- Growth hormone deficiency
- Hepatitis
- HIV/AIDS
- Multiple Sclerosis
- Osteoporosis
- Pulmonary disease
- Rheumatoid arthritis
- Psoriasis
- Transplants

Keep in Mind

Aetna Specialty Pharmacy delivers your specialty medication to your home, but it is not the same as the mail order service described in Mail Order Prescriptions – Aetna Rx Home Delivery. Deliveries of specialty medications are limited to a 30-day supply and the retail pharmacy copays apply.
The goal of Aetna Specialty Pharmacy is to work with you and your physician to ensure that you:

- Are on the right medication therapy;
- Have the medications and supplies you need; and
- Know how to administer your medications.

The Plan allows you to fill the first prescription for a specialty medication at your local retail pharmacy. **All refills must be obtained through Aetna Specialty Pharmacy.**

Ordering your medications from Aetna Specialty Pharmacy is easy:

- Your physician can fax the prescription to **1-866-329-2779.**
- You or your physician can mail the prescription to:
  
  Aetna Specialty Pharmacy
  503 Sunport Lane
  Orlando, FL 32809
- Your physician can call Aetna Specialty Pharmacy at **1-866-782-2779.**

Your medications will usually be shipped within 24-48 hours. A welcome packet in your first delivery will tell you about the services offered by Aetna Specialty Pharmacy, explain how to order refills, and provide important contact information.

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**For More Information**

You can reach Aetna Specialty Pharmacy 24 hours a day, 7 days a week, at **1-866-782-2779.**

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**Covered Drugs**

The Plan covers:

- Federal legend drugs (drugs that require a label stating: “Caution: Federal law prohibits dispensing without prescription”) or any other drug that, under the applicable state law, may be dispensed only upon the written prescription of a **physician.**
- Compounded medication, of which at least one ingredient is a federal legend drug. **Note:** Hormone replacement compounded medication (“bio-identical hormone replacement”) is not covered.
- Contraceptives, including:
  - Oral contraceptives;
  - Injectable contraceptives such as Depo Provera;
  - Patches;
  - Diaphragms; and
  - Rings.
- Diabetic needles and syringes.
- Insulin.
• Lifestyle performance drugs, in oral, injectable and topical (such as gels, creams, ointments and patches) forms:
  – Alprostadil (Muse, Edex, Caverject)
  – Phentolamine
  – Sildenafil citrate (Viagra)
  – Tadalafil (Cialis)
  – Vardenafil (Levitra)

The Plan’s coverage of sildenafil citrate, tadalafil, and vardenafil is limited to six pills per month at a retail pharmacy, and 18 pills per 90-day supply when purchased through the Plan’s mail-order service. If delivered in another form, Aetna will determine the cost-equivalent unit amount for a 30-day supply.

• Over-the-counter diabetic supplies.
• Prenatal and pediatric vitamins.

What the Prescription Drug Program Does Not Cover

The exclusions that apply to the medical plan (see What the Plan Does Not Cover) also apply to the prescription drug program. In addition, there are specific exclusions that apply to the prescription drug program. The prescription drug program does not cover the following prescription drug expenses:

• Administration or injection of any drug.
• Allergy sera and extracts.
• Any drug dispensed by a mail order pharmacy other than Aetna Rx Home Delivery.
• Any drug entirely consumed when and where it is prescribed.
• Any drug that does not, by federal or state law, require a prescription, such as an over-the-counter drug or equivalent over-the-counter product, even when a prescription is written for it.
• Any refill of a drug dispensed more than one year after the latest prescription for it, or as prohibited by law where the drug is dispensed.
• Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.
• Devices of any type (such as a spacer or nebulizer) used in connection with a prescription drug. Note that some devices may be covered as durable medical equipment or as part of another benefit.
• Durable medical equipment, monitors and other equipment.
• Experimental or investigational drugs or devices. This exclusion will not apply to drugs that:
  – Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or
  – Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
  – Aetna determines, based on available scientific evidence, are effective or show promise of being effective for the illness.
• Food items, including infant formula, nutritional supplements, vitamins (except prenatal and pediatric vitamins), medical foods and other nutritional items, even when the item is the only source of nutrition.
• Genetics: Any treatment, device, drug or supply to alter the body’s genes, genetic make-up or the expression of the body’s genes, except for the correction of congenital birth defects.
• Immunization or immunological agents.
• Infertility treatment. The Plan does not cover drugs used primarily for the treatment of infertility, including drugs for, or related to, artificial insemination, in vitro fertilization or embryonic transfer procedures.
• Inpatient drugs: Any drug provided by a health care facility or while you are an inpatient there. Also, any drug provided on an outpatient basis by a health care facility if benefits are paid for it under any other part of this Plan or another plan sponsored by your employer.
• More than a 30-day supply of a prescription filled at a retail pharmacy.
• More than the number of refills specified by the prescribing doctor. Aetna may require a new prescription or proof of need if the prescriber has not specified the number of refills or if the frequency or number of refills seems excessive under accepted medical practice standards.
• Non-emergency prescription drugs bought outside of the United States if:
  – You travel outside of the U.S. to obtain the prescription drugs or supplies, even if they would be covered by the Plan if purchased in the U.S.;
  – The drugs or supplies are unavailable or illegal in the U.S.; or
  – The purchase of these drugs or supplies outside of the U.S. is illegal.
• Smoking cessation aids.
• Weight loss and weight gain drugs, including (but not limited to) stimulants, preparations, foods, diet supplements, dietary regimens and appetite suppressants.

Some of the drugs, services and supplies listed above are not covered by the prescription drug program, but may be covered as medical plan expenses. If you have a question, call the Integrated Aetna Service Center at 1-888-263-8351 (select option 2).
WHAT THE PLAN DOES NOT COVER

This chapter contains a list of general services and supplies that are not covered by the Plan. In addition, some limits and exclusions apply to specific benefit provisions and expenses. These are noted in the chapters of this handbook that describe covered expenses and define terms, such as (but not limited to) What the Plan Covers, Behavioral Health Care, Prescription Drug Program and the Glossary. To fully understand what the Plan covers and does not cover, and how the Plan works, you should refer to these other chapters, as needed.

**Questions?**

If you have a question about what the Plan covers and does not cover, call the Integrated Aetna Service Center at 1-888-263-8351 (select option 2).

**General Exclusions**

The Plan does not cover charges:

- For cancelled or missed appointments.
- For care, treatment, services or supplies:
  - Given by an unlicensed provider; or
  - Outside the scope of the provider’s license.
- For care, treatment, services or supplies not prescribed, recommended or approved by a physician or dentist.
- For claim form completion.
- For drugs, devices, treatments or procedures that are experimental or investigational, except as described in What the Plan Covers and Prescription Drug Program.
- 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 services given by volunteers or persons who do not normally charge for their services.
- For services and supplies provided as part of treatment or care that is not covered by the Plan.
- For services and supplies provided in school, college or camp infirmaries.
- For services and supplies that are associated with injuries, illnesses or conditions suffered due to the acts or omissions of a third party, as determined by Aetna or its authorized representative.
- For services of a resident physician or intern if the charges are itemized separately. (Usually, such charges are included as part of the hospital’s room and board charges, in which case they would be covered.)
For services, supplies, medical care or treatment given by members of your immediate family (your spouse, domestic partner, child, step-child, brother, sister, in-law, parent or grandparent) or your household.

- Incurred before the date coverage starts or after the date coverage ends.
- In excess of the **recognized charge** for a service or supply given by an **out-of-network provider**.
- In excess of the **negotiated charge** for a given service or supply given by a **network provider**.
- Made only because you have health coverage or that you are not legally obligated to pay, such as:
  - Care in charitable institutions; or
  - Care in a hospital or other facility that is owned or operated by any government, except to the extent coverage is required by law.
- Related to employment or self-employment. This includes injuries that arise out of (or in the course of) any work for pay or profit, unless there is no other source of coverage or reimbursement available to you.
- Resulting from a felony that you commit or attempt to commit.
- To give you preferred access to a physician’s services, such as boutique or concierge physician practices.

**Alternative Health Care**

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

- Acupuncture, acupuncture therapy and acupressure, except when performed by a physician instead of anesthesia for surgery covered by the Plan.
- Alternative or non-standard allergy services and supplies, including (but not limited to):
  - Cytotoxicity testing (Bryan’s Test);
  - Skin titration (wrinkle method);
  - Treatment of non-specific candida sensitivity; and
  - Urine autoinjections.
- Aromatherapy, bioenergetic therapy, carbon dioxide therapy or massage therapy.
- Herbal medicine and holistic or homeopathic care, including drugs.
- Megavitamin therapy.
- Rolfing.
- Thermography and thermograms.
AMETEK, Inc. High PPO Option

Biological and Bionic
The Plan does not cover charges for:

- Artificial organs. The Plan does not cover any device intended to perform the function of a body organ.
- Blood processing, storage or replacement costs.
- Growth hormones (except when medically necessary and approved in advance by Aetna), surgical procedures or any other treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth.
- The services of blood donors, apheresis or plasmapheresis.

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

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

Custodial and Protective Care
The Plan does not cover charges for:

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

**Education and Training**
The Plan does *not* cover charges for:

- Services or supplies related to education, training, retraining services or testing, including:
  - Special education;
  - Remedial education;
  - Job training; or
  - Job hardening programs.
- Evaluation or treatment, regardless of the underlying cause of:
  - Learning disabilities;
  - Minimal brain dysfunction;
  - Developmental, learning and communication disorders; or
  - Behavioral disorders, including pervasive developmental disorders.
- Services, treatment, and education testing or training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

**Family Planning and Maternity**
The Plan does *not* cover:

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

**Foot Care**
The Plan does *not* cover services, supplies or devices to improve the comfort or appearance of toes, feet or ankles, including:

- Shoes (including orthopedic shoes), orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments, or other equipment, devices or supplies, even when required after treatment of an illness or injury that was covered by the Plan.
- Treatment of calluses, toenails, subluxations or fallen arches.
- Treatment for conditions caused by routine activities such as walking, running, working or wearing shoes.

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

- Because of a person’s past or present service in the armed forces of a government.
- Under any government law.
Health Exams
The Plan covers exams that are **necessary** to treat illness or injury, and routine preventive exams as described in the Preventive Care section. The Plan does **not** cover exams or related reports (including report presentation and preparation) required:

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

Home and Mobility
The Plan does not cover alterations or additions to your home, work place or other environment, or any related equipment or device, including (but not limited to):

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

The Plan does not cover vehicles and transportation devices, or alterations to any vehicle or transportation device.

Reproductive and Sexual Health
The Plan does **not** cover charges for:

- Therapy, supplies or counseling for sexual dysfunction or inadequacies with no physiological or organic basis.
- Treatment, drugs, services or supplies related to changing sex or sexual characteristics, including:
  - Surgical procedures to alter the function or appearance of the body;
  - Hormones or hormone therapy;
  - Prosthetic devices; and
  - Medical or psychological counseling.
• Treatment, services or supplies to treat sexual dysfunction, enhance sexual performance or enhance sexual desire, including:
  – Surgery, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sexual organ; and
  – Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

**Strength and Performance**

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

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

**Tests and Therapies**

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

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

**Vision, Speech and Hearing**

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

• Anti-reflective coatings and tinting of eyeglass lenses.
• Contact lenses.
• Eyeglasses, including duplicate or spare glasses, lenses or frames.
• Eye surgery to correct vision, including radial keratotomy, LASIK and similar procedures.
• Fitting of glasses or contact lenses for any purpose other than after cataract surgery.
• Hearing aids and their fitting, and hearing aid therapy or training.
• Routine hearing exams, with the exception of routine screenings provided as part of a covered well-child exam.
• Special vision services, such as non-prescription sunglasses and subnormal vision aids.
• Special vision procedures, such as orthoptics, vision therapy or vision training.
• Vision services mainly to correct refractive errors.
Weight Control Services

Regardless of the existence of comorbid conditions, the Plan does not cover charges for weight control, except as described in Bariatric Surgery. The Plan does not cover charges for:

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

Precertification

*Precertification Is Your Responsibility for Out-of-Network Care*
When you choose an out-of-network provider, you must get Aetna’s approval in advance for certain types of care. This process is called precertification. If you don’t get precertification when it’s required, your benefits may be reduced or coverage may be denied.

**Precertification** is a process that helps you and your **physician** determine whether the services being recommended are covered expenses by the Plan. It also allows Aetna to coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning) and to register you for specialized programs or case management when appropriate.

The precertification process does not restrict the course of treatment that a patient and his or her medical care provider may decide is appropriate or desirable. The patient and his or her provider are ultimately responsible for deciding on the course of treatment to be followed in any situation, regardless of whether it appears the Plan will pay for that care.

Precertification starts with a telephone call to the Integrated Aetna Service Center at **1-888-263-8351** (select option 2).

- If you use a **network provider**, your provider will make this call for you.
- If you intend to receive care from an **out-of-network provider**, you must make the call.

The precertification requirement does not apply to an individual who is covered by this Plan, but has Medicare as his or her primary coverage.

**When You Need To Precertify Care**

*You are responsible for getting precertification for the services in the following chart if your care will be given by an out-of-network provider.*

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>When You Need to Precertify Out-of-Network Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient Care</td>
<td>To request precertification, call the Integrated Aetna Service Center at <strong>1-888-263-8351</strong> (select option 2) as follows:</td>
</tr>
<tr>
<td></td>
<td>- emergency admission: within 48 hours of admission or as soon as reasonably possible</td>
</tr>
<tr>
<td></td>
<td>- urgent admission: before you are scheduled to be admitted</td>
</tr>
<tr>
<td></td>
<td>- other admissions: at least 14 calendar days prior to admission</td>
</tr>
</tbody>
</table>
### Alternatives to Hospital Inpatient Care

You need to request precertification for the following hospital alternatives if your provider is not in the Aetna network:

- skilled nursing facility care
- home health care services
- hospice care – inpatient and outpatient
- private duty nursing

To request precertification, call the Integrated Aetna Service Center at **1-888-263-8351** (select option 2) as follows:

- inpatient confinements; same as hospital inpatient care (above)
- outpatient care:
  - non-emergency care – at least 14 calendar days in advance or as soon as reasonably possible
  - emergency care – as soon as reasonably possible

### Inpatient Behavioral Health Care

You need to request precertification for inpatient confinement in an out-of-network hospital or treatment facility

To request precertification, call the Integrated Aetna Service Center at **1-888-263-8351** (select option 2) as follows:

- emergency admission: within 48 hours of admission or as soon as reasonably possible
- urgent admission: before you are scheduled to be admitted
- other admissions: at least 14 calendar days prior to admission

### Outpatient Behavioral Health Care

Precertification is recommended for certain services. You should call Aetna Behavioral Health for the following out-of-network services:

- Amytal interview
- applied behavioral analysis
- biofeedback
- intensive outpatient programs
- neuropsychological testing
- outpatient detoxification
- outpatient electroconvulsive therapy
- partial hospitalization programs
- psychiatric home care services
- psychological testing

To request precertification, call the Integrated Aetna Service Center at **1-888-263-8351** (select option 2) as follows:

- inpatient confinements; same as hospital inpatient care (above)
- outpatient care:
  - non-emergency care – at least 14 calendar days in advance or as soon as reasonably possible
  - emergency care – as soon as reasonably possible
Aetna will notify you, your **physician** and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days must be certified. You, your physician or the facility will need to call Aetna at the number on your ID card no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a copy of this letter.

**If You Don’t Precertify**

You must comply with the precertification requirements in order to receive the full out-of-network benefits. If you don’t call when required, the medical plan may apply a penalty or deny coverage for your hospital, skilled nursing facility, home health care, hospice and private duty nursing expenses:

<table>
<thead>
<tr>
<th>If precertification is:</th>
<th>then:</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ requested and approved</td>
<td>the charges are covered.</td>
</tr>
<tr>
<td>➢ requested and denied</td>
<td>the charges are not covered.</td>
</tr>
<tr>
<td>➢ not requested, and the care is necessary</td>
<td>you must pay the first $1,000 of covered expenses before the Plan begins to pay benefits</td>
</tr>
<tr>
<td>➢ not requested, and the care is not necessary</td>
<td>the charges are not covered.</td>
</tr>
</tbody>
</table>

Precertification is recommended for durable medical equipment, maternity care by your physician, transplants and non-emergency ambulance services so you know ahead of time whether the Plan will cover the services and the benefit level that will apply. If, however, you do not get these services and supplies precertified, there is no penalty.

**Precertification of Behavioral Health Care**

Precertification is required for all inpatient mental health and substance abuse treatment, and recommended for certain outpatient behavioral health services. When you need behavioral health care, contact Aetna Behavioral Health at **1-800-842-8032**. A behavioral health coordinator will confidentially evaluate your situation and refer you to a **behavioral health provider** who is suited to your needs.

If you don’t call when required, the medical plan may apply a penalty or deny coverage for your inpatient care:

<table>
<thead>
<tr>
<th>If precertification is:</th>
<th>then the charges are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ requested and approved</td>
<td>covered.</td>
</tr>
<tr>
<td>➢ requested and denied</td>
<td>not covered.</td>
</tr>
<tr>
<td>➢ not requested, and the care is necessary</td>
<td>you must pay the first $1,000 of covered expenses before the Plan begins to pay benefits</td>
</tr>
<tr>
<td>➢ not requested, and the care is not necessary</td>
<td>not covered.</td>
</tr>
</tbody>
</table>
Precertification is recommended for the outpatient services shown in the chart in *When You Need to Precertify Care* so you know ahead of time whether the Plan will cover the services and the benefit level that will apply. If, however, you do not get these services precertified, there is no penalty.

**Discharge Planning**

Part of the precertification process for inpatient care may be discharge planning to determine the appropriate setting and arrange for necessary medical support services when there are alternatives to a hospital confinement.

The discharge planning process is a joint effort between you, the hospital, your physician and Aetna. Its aim is to ensure that continued care will be carefully planned and given in the most appropriate and cost-effective setting.

The discharge planning process will:

- Identify patients who are candidates for early discharge from the hospital when the services they require can be effectively delivered at an alternate site.
- Facilitate the transfer of those patients to an appropriate, more cost-effective setting.
- Assist patients who, if it were not for a special problem, could receive treatment on an outpatient basis.

**Subrogation and Reimbursement**

If you receive benefits as the result of an illness or injury caused by another party, the Plan has the right to be reimbursed for those benefits from any settlement or payment you receive from the person who caused the illness or injury. This process is called subrogation and reimbursement.

**Definitions**

The description of the subrogation and reimbursement process uses three terms that you need to understand. As used here, the term:

- “third party” means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as “third party injuries.”
- “responsible party” includes any party responsible for payment of expenses associated with the care or treatment of third party injuries.
- “you” or “your” includes anyone on whose behalf this Plan pays or provides any benefits.

**Right of Recovery**

When the Plan pays benefits to you for expenses incurred due to third party injuries, then the Plan retains the right to repayment of the full cost of all benefits provided by the Plan on your behalf that are associated with the third party injuries. The Plan’s rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of the third party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers’ Compensation or disability award or settlement;
• Medical payments coverage under any:
  – automobile policy;
  – premises or homeowners’ medical payments coverage; or
  – premises or homeowners’ insurance coverage; and
• Any other payments from a Responsible Party or another source intended to compensate you for injuries resulting from an accident or alleged negligence.

When You Accept Plan Benefits
By accepting benefits under this Plan, you specifically acknowledge the Plan’s right of subrogation. When this Plan pays health care benefits for expenses incurred due to third party injuries, the Plan shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this plan. The Plan may proceed against any party with or without your consent.

By accepting benefits under this Plan, you also specifically acknowledge the Plan’s right of reimbursement. This right of reimbursement attaches to any payment received by you or your representative from any party responsible for paying for expenses associated with the care or treatment of third party injuries. By providing any benefit under this Plan, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this Plan. The Plan’s right of reimbursement is cumulative with and not exclusive of the Plan’s subrogation right and the Plan may choose to exercise either or both rights of recovery.

By accepting benefits under this Plan, you or your representatives further agree to:
• Notify the Claims Administrator, Aetna, in writing, within 30 days of the time when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third party injuries sustained by you;
• Cooperate with Aetna and its designees and do whatever is necessary to secure the Plan’s rights of subrogation and reimbursement under this booklet;
• Give the Plan a first-priority lien on any recovery, settlement, or judgment or other source of compensation that may be had from any party to the extent of the full cost of all benefits associated with third party injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
• Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due to the Plan as reimbursement for the full cost of all benefits associated with third party injuries paid by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement), unless otherwise agreed to by Aetna in writing;
• Do nothing to prejudice the Plan’s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery that specifically attempts to reduce or exclude the full cost of all benefits paid by the Plan; and
• Serve as a constructive trustee for the benefits of this Plan over any settlement or recovery funds received as a result of third party injuries.

The Plan’s recovery rights under this provision are first priority rights and the Plan is entitled to reimbursement even if such reimbursement results in a recovery to you that is insufficient to compensate you in whole or in part for your damages from a third party injury. The Plan may
recover the full cost of all benefits paid by this Plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from the Plan’s recovery, and the Plan and Claim Administrator are not required to pay or contribute to paying court costs or attorney’s fees for the attorney hired by you to pursue your claim or lawsuit against any third party without the prior express written consent of the Claims Administrator.

**If You Do Not Follow the Process**

In the event you or you representative fail to cooperate with the Plan and its Claims Administrator, you shall be responsible for all benefits paid by this Plan, in addition to costs and attorney’s fees incurred by the Plan and its Claims Administrator in obtaining repayment.
CLAIMS AND APPEALS

The Plan has procedures for submitting claims, making decisions on claims and filing an appeal when you don’t agree with a claim decision. You, Aetna and AMETEK must meet certain deadlines that are assigned to each step of the process, depending on the type of claim.

Claims Procedures: Overview

Do I Have To Maintain Records?

You only have to maintain records for out-of-network benefits. Please keep careful, complete records of any out-of-network expenses for each covered family member. The records will be required when you submit a request for out-of-network benefits.

How Will Benefits Be Paid?

When you use network services in accordance with the network rules, benefits are automatically paid to the provider through the network. Your only expense is the copayment, deductible or coinsurance, if any.

Out-of-network benefits are not automatically paid if you or a covered dependent do not follow network rules. They will be paid only after a claim form and necessary written proof to support the claim (itemized bills) are received by the Network Administrator.

Out-of-network benefit payments are payable directly to the provider if you so specify when the claim is filed. If you do not so specify, out-of-network benefits are payable to you.

Also, if you are a minor or otherwise legally unable to give a valid release, or if a benefit is payable to your estate, the Network Administrator has the right to pay up to $1,000 of any benefit directly to any of your relatives whom the Network Administrator may determine to be entitled to the payment.

When Should I Submit a Request for Benefit Payment?

If you use the network in accordance with the network rules, you do not have to request any benefit payment; you only pay the copayment, deductible or coinsurance, if any.

When out-of-network benefits apply, you should report medical expenses promptly. You must report expenses within 12 months of the date they are incurred in order to be considered for coverage under the Plan. Forms and instructions for requesting out-of-network benefit payment may be obtained through the Integrated Aetna Service Center at 1-888-263-8351 (select option 2) or online at www.aetna.com.

What If a Claim Is Denied?

The Plan has procedures for you to follow if you are dissatisfied with a decision that Aetna has made.
Types of Claims

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

- **Urgent care claim:** A claim for medical care or treatment where delay could:
  - Seriously jeopardize your life or health, or your ability to regain maximum function; or
  - Subject you to severe pain that cannot be adequately managed without the requested care or treatment.

- **Pre-service claim:** A claim for a benefit that requires Aetna’s approval of the benefit in advance of obtaining medical care (for example, precertification).

- **Concurrent care claim extension:** A request to extend a course of treatment that was previously approved.

- **Concurrent care claim reduction or termination:** A decision to reduce or terminate a course of treatment that was previously approved.

- **Post-service claim:** A claim for a benefit that is not a pre-service claim.

Filing Claims

If you use an out-of-network provider, you must file a claim to be reimbursed for covered expenses. You can obtain a claim form from the Integrated Aetna Service Center at 1-888-263-8351 (select option 2), or by going online at www.aetna.com. The form has instructions on how, when and where to file a claim.

File your claims promptly – **the filing deadline is 12 months after the date you incur a covered expense.** If, through no fault of your own, you are unable to meet that deadline, your claim will be accepted if you file it as soon as possible.

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

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

Please Note

If a service or supply requires preauthorization and it is not possible in the circumstances to obtain prior approval, or the situation is one where obtaining prior approval could seriously jeopardize your life or health, the benefit will not be denied for lack of prior approval.
Time Frames for Claim Processing

Aetna will make a decision on your claim.

- **If Aetna approves the claim**, benefits are payable to you. Aetna has the right, however, to pay any benefits directly to your physician or other care provider, and will do so unless you tell Aetna otherwise when you file the claim.

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

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Aetna Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care claim</td>
<td>As soon as possible, but not later than 72 hours</td>
</tr>
<tr>
<td>Pre-service claim</td>
<td>15 calendar days</td>
</tr>
</tbody>
</table>
| Concurrent care claim extension      | ➢ Urgent care claim – as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours before the expiration of the approved treatment  
➤ Other claims – 15 calendar days |
| Concurrent care claim reduction or termination | With enough advance notice to allow you to appeal |
| Post-service claim                   | 30 calendar days          |

**Extensions of Time Frames**

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

- **For urgent care claims**: If Aetna does not have enough information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after 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 do not provide the information, the claim will be denied.

If an extension of time is needed because Aetna needs more information to process your post-service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. Your claim will be on hold during this 45-day period. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you do not provide the information, your claim will be determined without the information.
Notice of Claim Denial

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

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

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

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

If your claim for benefits is denied, you will receive a written notification of the denial of benefits that gives you:

- The specific reason or reasons for the adverse determination;
- References to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why this material or information is necessary;
- A description of the Plan’s review procedures and the time limits applicable to these procedures, including a statement of your right to bring a civil action under ERISA following an adverse benefit determination on review;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that the rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided to you upon request free of charge;
- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided upon request, free of charge; and
- In the case of a claim involving urgent care, a description of the expedited review process applicable to urgent care claims.

If the Network Administrator does not furnish you with the initial determination within the applicable time period described above, your claim will be deemed exhausted at the expiration of the applicable period, and you may commence your appeal or pursue any available remedies under Section 502(a) of ERISA at that time.
Appealing a Medical Claim Decision

How to Appeal a Claim Denial – Standard Appeals

You may file a written request for review if you believe that your claim for benefits was denied or deemed exhausted in error, based on the rules and coverages described in this booklet. In order to have the Network Administrator consider your request for review, your request must be submitted within 180 days after:

- Your receipt of the written notice of the denial; or
- The date that the claim is deemed exhausted.

Your appeal should include:

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

Send your appeal to Aetna at the address shown on your ID card.

The Plan provides for two standard levels of appeal. 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.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Level One Appeal</th>
<th>Level Two Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care claim</td>
<td>36 hours Review provided by Plan personnel not involved in making the adverse benefit determination</td>
<td>36 hours Review provided by Plan personnel not involved in making the adverse benefit determination</td>
</tr>
<tr>
<td>Pre-service claim</td>
<td>15 calendar days Review provided by Plan personnel not involved in making the adverse benefit determination</td>
<td>15 calendar days Review provided by Plan personnel not involved in making the adverse benefit determination</td>
</tr>
<tr>
<td>Concurrent care claim</td>
<td>Treated like an urgent care claim or a pre-service claim, depending on the circumstances</td>
<td>Treated like an urgent care claim or a pre-service claim, depending on the circumstances</td>
</tr>
<tr>
<td>Post-service claim</td>
<td>30 calendar days Review provided by Plan personnel not involved in making the adverse benefit determination</td>
<td>30 calendar days Review provided by Plan personnel not involved in making the adverse benefit determination</td>
</tr>
</tbody>
</table>
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.

You may submit written comments, documents, records and other information relating to your claim. You will also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. Aetna will determine, in its sole discretion, whether documents, records and information are relevant to your claim, subject to applicable regulations. You may, upon request and free of charge, obtain the identity of any medical or vocational expert whose advice was obtained in connection with an adverse benefit determination regarding your claim, whether or not the expert’s advice was relied upon in making a benefit determination.

In reviewing your claim, Aetna will take into account all comments, documents, records and other information you submit that relate to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. Additionally, Aetna’s review of your claim will not afford deference to the initial adverse benefit determination and will be conducted by a person or entity who is neither the individual who made the initial adverse benefit determination regarding your claim nor a subordinate of such individual. If the initial adverse benefit determination was based in whole or in part on a medical judgment, the person or entity deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the initial adverse benefit determination regarding the claim nor a subordinate of such individual.

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

Notice of Decision on Appeal

You will receive written notification of Aetna’s decision upon review. If your claim is denied on review, the notice shall include:

- The specific reason or reasons for the denial of the claim;
- References to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits, and that Aetna will determine whether documents, records and information are relevant to your claim under applicable regulations;
- If this notice is being issued in response to your first level of appeal: A statement of your right to file a second level appeal.
  If this notice is being issued in response to your second level of appeal: A statement of your right to bring an action under ERISA or under the Voluntary Appeal Process (described below);
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request; and
AMETEK, Inc. High PPO Option

If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to your medical circumstances will be provided free of charge upon request.

If the decision on review is not furnished within the applicable time period specified in the subsection entitled How to Appeal a Claim Decision – Standard Appeals, the claim will be deemed exhausted on review at the expiration of that period and you may either file a voluntary appeal or pursue any available remedies under Section 502(a) of ERISA at that time.

Appealing Your Standard Appeal Claim Decision – Voluntary Appeals

You may file a voluntary appeal of any final standard appeal determination, as described above. The voluntary appeal should be made for external review if the appeal qualifies or to the Plan Administrator if the appeal does not qualify for external review. In addition, you may file a voluntary appeal to the Plan Administrator if you are dissatisfied with the determination made by external review.

You must complete all of the levels of standard appeal described above before you can appeal for external review or to the Plan Administrator. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal. You must request this voluntary appeal level of review within 60 days after you receive the final denial notice under the standard appeal processes.

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

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

External Review

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

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

Keep in Mind

You do not have to file for voluntary review. After you exhaust the Plan’s two standard levels of appeal, you may pursue any available remedies under Section 502(a) of ERISA. Your decision to decline the voluntary review process is not considered a failure to exhaust your administrative remedies.
Claims That Qualify for External Review

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

- You have exhausted the Plan’s standard appeal process (level one and level two); or
- Aetna (or the Plan or its designee) has not strictly followed all claim determination and appeal requirements under federal law.

A denial based upon your eligibility is not eligible for external review.

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

Exhaustion of the Standard Appeal Process

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

Exception

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

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

Deadline for Requesting an External Review

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

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

Preliminary Review

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

- You were covered under the Plan at the time the service was requested or provided; and
- The adverse determination does not relate to eligibility;
AMETEK, Inc. High PPO Option

- You have exhausted the standard appeals process (unless deemed exhaustion applies); and
- You have provided all paperwork necessary to complete the external review.

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

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

**Referral to ERO**

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

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

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

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

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

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

- You receive an adverse benefit determination, if:
  - That determination involves a medical condition for which the time frame for completing an expedited standard appeal (the level one and level two appeal process) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; and
  - You have filed a request for an expedited standard appeal; or
- You exhaust the standard appeal process (level one and level two), if:
  - You have a medical condition where the time frame for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
  - It concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

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

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

**Appeal to the Plan Administrator**

If you choose to appeal to the Plan Administrator following an adverse determination by external review (where applicable) or an adverse determination at the final level of standard appeals, you must do so in writing, and you should send the following information:

- The specific reason(s) for the appeal;
- Copies of all past correspondence with Aetna, including any EOBs; and
- Any applicable information that you have not yet sent to Aetna.

If you file a voluntary appeal, you will be deemed to authorize the Plan Administrator to obtain information from Aetna relevant to your claim.

Mail your written appeal directly to:

Flexible Benefits Plan Administrative Committee
AMETEK, Inc.
1100 Cassatt Road
Berwyn, PA 19312

The Plan Administrator will review your appeal. The Plan Administrator’s reviewer will evaluate your claim within 60 days after you file your appeal and make a decision. If the reviewer needs more time, the reviewer may take an additional 60-day period. The reviewer will notify you in
advance of this extension. The reviewer will follow relevant internal rules maintained by the Network Administrator to the extent they do not conflict with its own internal guidelines. The reviewer will notify you of the final decision on your appeal electronically or in writing. The written notice will give you the reason for the decision and what Plan provisions apply. All decisions by the Plan Administrator with respect to your claim shall be final and binding.

Claim Fiduciary

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

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

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

The Plan provides for two standard levels of appeal for adverse benefit determinations. Aetna is the Claim Fiduciary that will provide full and fair review for all first and second level appeals. Aetna serves as Claim Fiduciary for the voluntary external review. The Plan also provides a voluntary appeal to the Plan Administrator, which acts as Claim Fiduciary for this purpose.

If You Have a Complaint About the Network

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

Recovery of Overpayment

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

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

This right does not affect any other right of overpayment recovery the Plan may have.
Legal Action
No legal action can be brought to recover a benefit after three years from the deadline for filing claims.

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

Concurrent Review and Discharge Planning
The following items apply if the Plan requires certification of any confinement, services, supplies, procedures or treatments:

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

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

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

Important Terms

Allowable Expenses

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

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient’s stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage of hospital private rooms) is not an allowable expense.

2. If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.

3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.

4. If a person is covered by one plan that calculates its benefits or services on the basis of reasonable or recognized charges and another plan that provides its benefits or services on the basis of negotiated charges, the primary plan’s payment arrangements shall be the allowable expense for all the plans.

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

Custodial Parent

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

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

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

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

This Plan

The Plan described in this handbook, together with the AMETEK, Inc. Health and Welfare Plan Overview Booklet.

Which Plan Is Primary?

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

<table>
<thead>
<tr>
<th>If . . .</th>
<th>Then . . .</th>
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<tbody>
<tr>
<td>1. One plan has a COB provision and the other plan does not</td>
<td>The plan without a COB provision determines its benefits and pays first.</td>
</tr>
<tr>
<td>2. One plan covers you as a dependent and the other covers you as an employee or retiree</td>
<td>The plan that covers you as an employee or retiree determines its benefits and pays first.</td>
</tr>
<tr>
<td>3. You are eligible for Medicare and not actively working</td>
<td>These Medicare Secondary Payer rules apply:</td>
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<tr>
<td></td>
<td>➢ The plan that covers you as a dependent of a working spouse determines its benefits and pays first.</td>
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<tr>
<td></td>
<td>➢ Medicare pays second.</td>
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<tr>
<td></td>
<td>➢ The plan that covers you as a retired employee pays third.</td>
</tr>
<tr>
<td>If . . .</td>
<td>Then . . .</td>
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<tr>
<td>4. A child’s parents are married or living together (whether or not married)</td>
<td>The plan of the parent whose birthday occurs earlier in the calendar year determines its benefits and pays first. If both parents have the same birthday, the plan that has covered the parent the longest determines its benefits and pays first. But if the other plan does not have this &quot;parent birthday&quot; rule, the other plan’s COB rule applies.</td>
</tr>
<tr>
<td>5. A child’s parents are separated or divorced with joint custody, and a court decree does not assign responsibility for the child’s health expenses to either parent, or states that both parents are responsible for the child’s health coverage</td>
<td>The “birthday rule” described above applies.</td>
</tr>
<tr>
<td>6. A child’s parents are separated or divorced, and a court decree assigns responsibility for the child’s health expenses to one parent</td>
<td>The plan covering the child as the assigned parent’s dependent determines its benefits and pays first.</td>
</tr>
</tbody>
</table>
| 7. A child’s parents are separated, divorced or not living together (whether or not they have ever been married) and there is no court decree assigning responsibilities for the child’s health expenses to either parent | Benefits are determined and paid in this order:  
  ➢ The plan of the custodial parent pays, then  
  ➢ The plan of the spouse of the custodial parent pays, then  
  ➢ The plan of the non-custodial parent pays, then  
  ➢ The plan of the spouse of the non-custodial parent pays.                                                                                     |
| 8. You have coverage as:  
  ➢ an active employee (that is, not as a retiree or laid off employee) and also have coverage as a retired or laid-off employee; or  
  ➢ the dependent of an active employee and also have coverage as the dependent of a retired or laid off employee | The plan that covers you as an active employee or as the dependent of an active employee determines its benefits and pays first.  
This rule is ignored if the other plan does not contain the same rule.  
Note: this rule does not apply if rule 2 (above) has already determined the order of payment.                                                 |
If . . . | Then . . .
--- | ---
9. You are covered under a federal or state right of continuation law (such as COBRA) | The plan other than the one that covers you under a right of continuation law will determine its benefits and pay first. This rule is ignored if the other plan does not contain the same rule. Note: this rule does not apply if rule 2 (above) has already determined the order of payment.
10. The above rules do not establish an order of payment | The plan that has covered you for the longest time will determine its benefits and pay first.

**Effect of Other Plan Benefits on This Plan’s Benefits**

When the other plan pays first, this Plan may reduce its benefits so that the combined benefits paid by all plans are not more than 100 percent of the total covered expenses.

This means that the Plan will:

- Calculate the benefit it would pay if there were no other coverage; *then*
- Add the amount paid by any other plan(s); *then*
- Reduce the benefits paid by this Plan so the combined total of benefits paid by all plans is no more than the total of covered expenses.

This prevents the sum of your benefits from being more than your actual expenses for covered services.

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

**Right to Receive and Release Needed Information**

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

**Facility of Payment**

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

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

Coordination of Benefits with Medicare

A person is eligible for Medicare if he or she:

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

When you are eligible for Medicare, Aetna must determine whether this Plan or Medicare is the primary plan.

When This Plan Is Primary

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

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

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

End-Stage Renal Disease

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

Medicare becomes the primary plan beginning with the 31st month of Medicare eligibility due to ESRD.
When Medicare Is Primary
Medicare is the primary plan, and this Plan is secondary, if a covered person is eligible for Medicare and is:

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

How Medicare Parts A and B Affect Your Plan Benefits
When Medicare is your primary plan, as described above, this Plan is secondary and pays benefits based on:

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

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

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

Keep in Mind
Once you are eligible for Medicare, the Plan’s benefits are calculated as though you have enrolled in Part B – **whether or not you’ve actually enrolled**. This is why it’s important to enroll in Part B as soon as you become eligible for it.
The Glossary defines the words and phrases in **bold type** that appear throughout the text of this handbook.

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

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

**Coinsurance**
The sharing of covered expenses by the Plan and the covered person. The percentage of covered expenses paid by the Plan is the Plan’s coinsurance. The percentage of covered expenses that you pay is your coinsurance.

**Companion**
This is a person who needs to be with an **NME patient** to enable him or her:
- To receive services in connection with an NME (National Medical Excellence) procedure or treatment on an inpatient or outpatient basis; or
- To travel to and from the facility where treatment is given.

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

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

**Deductible**
This is the amount of covered expenses that a Plan participant pays each calendar year before the Plan begins paying benefits for certain expenses.

**Dentist**
This means a legally qualified dentist or a **physician** licensed to do the dental work he or she performs.
Detox/Detoxification
This is care mainly to overcome the aftereffects of a specific episode of drinking or substance abuse.

Directory
This is a listing of network providers in the service area covered under the Plan. A current list of network providers may be obtained by calling the Integrated Aetna Service Center at **1-888-263-8351** (select option 2) and is also available through Aetna’s online provider directory, DocFind at [www.aetna.com](http://www.aetna.com).

Durable Medical Equipment
This is equipment – and the accessories needed to operate it – that is:
- Made to withstand prolonged use;
- Made for and used mainly in the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to people who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

The Plan does not allow for more than one item of equipment for the same or similar purpose. Durable medical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over-bed tables, elevators, communication aids, vision aids and telephone alert systems.

Effective Treatment of a Mental Disorder
This is a program that:
- Includes a written treatment plan that is prescribed and supervised by a behavioral health provider;
- Includes follow-up treatment; and
- Is for a disorder that can be changed for the better.

Effective Treatment of Alcohol or Substance Abuse
This means a program of alcohol or substance abuse therapy that is prescribed and supervised by a **behavioral health provider** and either:
- Has a follow-up therapy program directed by a physician on at least a monthly basis; or
- Includes meetings at least once a month with organizations devoted to the treatment of alcohol or substance abuse.

Note: Maintenance care (providing an alcohol- and/or drug-free environment) and **detoxification** are not considered “effective treatment.”
Emergency Admission
This means a hospital admission when the physician admits you to the hospital right after the sudden and, at that time, unexpected onset of a change in your physical or mental condition:

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

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

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

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

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

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

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- It does not have the approval required for marketing by the U.S. Food and Drug Administration; or
- A nationally recognized medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
• It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and U.S. Department of Health and Human Services; or
• The written protocol(s) or written informed consent used by the treating facility – or another facility studying the same drug, device, treatment or procedure – states that it is experimental, investigational or for research purposes.

**Where Can I Find More Information?**

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

**Generic Drug**

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

**Home Health Care Agency**

This is an agency that:

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

**Home Health Care Plan**

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

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

**Hospice Care**

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

This is an agency or organization that:

- Has **hospice care** available 24 hours a day;
- Meets any licensing or certification standards established by the jurisdiction where it is located;
- Provides:
  - Skilled nursing services; and
  - Medical social services; and
  - Psychological and dietary counseling;
- Provides, or arranges for, other services that include:
  - Physician services; and
  - Physical and occupational therapy; and
  - Part-time home health aide services that consist mainly of caring for terminally ill people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management;
- Has at least the following personnel:
  - One physician; and
  - One RN; and
  - One licensed or certified social worker employed by the agency;
- Establishes policies about how hospice care is provided;
- Assesses the patient’s medical and social needs;
- Develops a hospice care program to meet those needs;
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or direct the agency;
- Permits all area medical personnel to utilize its services for their patients;
- Keeps a medical record for each patient;
- Uses volunteers trained in providing services for non-medical needs; and
- Has a full-time administrator.

**Hospice Care Program**

This is a written plan of **hospice care** that:

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

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

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

LPN
This means a licensed practical nurse.

Mail Order Pharmacy
An establishment where prescription drugs are legally dispensed by mail.

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

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


**Morbid Obesity**

This means:

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

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

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

**NME Patient**

This is a person who:

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

**Necessary/Medically Necessary**

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

- Provided in accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration;
- Considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, physician, dentist or other health care provider; and
- Not more costly than an alternative service or sequence of services that would be at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
For these purposes, “generally accepted standards of medical or dental practice” means standards that are:

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

**Negotiated Charge**

This is the maximum fee a network provider has agreed to charge for any service or supply for the purpose of benefits under this Plan.

**Network Care**

This is a health care service or supply furnished by:

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

**Network Pharmacy**

A pharmacy, including a mail order pharmacy, that has a contract with Aetna to dispense drugs to persons covered under this Plan, but only while:

- The contract remains in effect; and
- The pharmacy dispenses prescription drugs under the terms of its contract with Aetna.

**Network Provider**

This is a health care provider who has contracted to furnish services or supplies for a negotiated charge, but only if the provider is, with Aetna’s consent, included in the directory as a preferred care provider for the service or supply involved.

**Non-Occupational Disease**

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

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

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

- Are covered under any type of Workers’ Compensation law; and
- Are not covered for that disease under such law.
Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:
- Result from (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Non-Urgent Admission
An admission that is not an emergency admission or an urgent admission.

Out-of-Network Care
This is a health care service or supply provided by an out-of-network provider if, as determined by Aetna:
- The service or supply could have been provided by a network provider; and
- The provider does not belong to one or more of the provider categories in the directory.

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

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

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

Pharmacy
An establishment where prescription drugs are legally dispensed.

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

Precertification
This is a review of certain types of care to determine whether the proposed care is covered by the Plan. This review takes place before the care is given.

Prescriber
Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a prescription drug.
**Prescription**
A prescriber’s order for a prescription drug. If it is an oral order (such as a phoned-in prescription), it must be put in writing promptly by the pharmacy.

**Prescription Drugs**
Any of the following:

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

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

- Mainly provides a program for the diagnosis, evaluation and treatment of mental disorders or alcohol or substance abuse.
- Is not mainly a school or custodial, recreational or training institution.
- Provides infirmary-level medical services.
- Provides, or arranges with a hospital in the area to provide, any other medical service that may be needed.
- Is supervised full-time by a psychiatric physician who is responsible for patient care.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides at all times, skilled nursing services by licensed nurses who are supervised by a full-time RN.
- Prepares and maintains a written plan of treatment for each patient. The plan must be supervised by a psychiatric physician.
- Charges for its services.
- Meets licensing standards.

**RN**
This means a registered nurse.
Recognized Charge

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

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

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

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

Aetna may reduce the recognized charge to address the appropriate billing of services, taking into account factors such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and **necessary** for the service;
- Whether follow-up care is included;
- Whether there are any other factors that modify or make the service unique; and
- Whether any services are part of or incidental to the primary service provided if the charge includes more than one claim line.

Aetna’s reimbursement policies are based on:

- Aetna’s review of policies developed for Medicare;
- Generally accepted standards of medical and dental practice; and
- The views of physicians and dentists practicing in the relevant clinical areas.
- Aetna uses a commercial software package to administer some of these policies.

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

**Residential Treatment Center**

This is an institution that:

- Specializes in the treatment of psychological and social disturbances that are the result of mental health or substance abuse conditions;
- Provides a sub-acute, structured, psychotherapeutic treatment program under the supervision of physicians;
- Provides 24-hour care, in which the patient lives in an open setting; and
- Is licensed as a residential treatment center in accordance with the laws of the appropriate legally authorized agency.
Room and Board Charges
Charges made by an institution for room and board and other necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

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

Skilled Nursing Facility
This is an institution that:

- Is licensed or approved under state or local law;
- Qualifies as a skilled nursing facility under Medicare, or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities.
- Is primarily engaged in providing skilled nursing care and related services for residents who need:
  - Medical or nursing care; or
  - Rehabilitation services because of injury, illness or disability;
- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - Professional nursing care by an RN, or by an LPN directed by a full-time RN; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities;
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time RN;
- Is supervised full-time by a physician or RN;
- Keeps a complete medical record for each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for people who are mentally retarded, or for custodial or educational care;
- Is not mainly a place for the care and treatment of alcoholism, substance abuse or mental disorders, and
- Charges for its services.
- A skilled nursing facility may be a rehabilitation hospital or a portion of a hospital designated for skilled or rehabilitation services.

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

This is a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians, at least one of whom is on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed, and during the recovery period.
- Extends surgical staff privileges to physicians who practice surgery in an area hospital and to dentists who perform oral surgery.
- Has at least two operating rooms and one recovery room.
- Provides or arranges with a medical facility in the area for diagnostic X-ray and laboratory services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an RN.
- Is equipped and has staff trained to handle medical emergencies.
- Must have a physician trained in CPR, a defibrillator, a tracheotomy set and a blood volume expander.
- Has a written agreement with an area hospital for the immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them.
- Provides an ongoing quality assurance program that includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record for each patient.

**Terminally Ill**

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

**Treatment Facility (for a mental disorder)**

This is an institution that:

- Mainly provides a program for the diagnosis, evaluation and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
• Provides, at all times, psychiatric social work and nursing services.
• Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time RN.
• Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician.
• Charges for its services.
• Meets licensing standards.

**Treatment Facility (for alcohol or substance abuse)**

This is an institution that:

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

**Urgent Admission**

An urgent admission is one where the physician admits you to the hospital because of:

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

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

**Urgent Care Provider**

This is a freestanding medical facility that:

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

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

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

**Urgent Condition**

This is a sudden illness, injury or condition that:

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

**Walk-In Clinic**

A freestanding health care facility that:

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

A walk-in clinic must:

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