

State of Delaware

**Health Maintenance Organization (HMO)
Summary Plan Description**

Administered by Aetna

WELCOME

This health care plan was selected by the State Employee Benefits Committee of the State of Delaware. Our goal is your good health. To achieve this goal, we encourage preventive care in addition to covering you when you are sick or injured.

Please note: This is an HMO (Health Maintenance Organization) health plan. You select a PCP. To receive benefits, your PCP manages all your health care needs. It is important to contact your PCP when you need care.

As used in this Summary Plan Description (SPD), “HMO” refers to HMO type benefits that are self-funded by the State of Delaware and administered by Aetna.

This SPD is not a contract. It explains your plan for easy reference. This SPD describes your health plan in effect as of July 1, 2007. It replaces all previous SPDs.

We wish you the best of health!

How To Use Your Summary Plan Description (SPD)

This SPD is your guide to the benefits available through your health plan. Please read it carefully and refer to it when you need information about this HMO, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about special programs and value added benefits available through your health plan.

If you cannot find an answer to your question(s) in the booklet, call the Aetna Member/Customer Services toll free number on your ID card. A trained representative will be happy to help you.

This booklet is not a contract. It explains your plan for easy reference. The benefits and terms and conditions of your plan are in an Account Contract on file with the Statewide Benefits Office, OMB. The Account Contract is the final determination of the benefits and rules of your plan.

Tips for New Plan Participants:

- Keep this SPD where you can easily refer to it.
- Keep your ID card(s) in your wallet - always show your card when you receive care.
- Post your Primary Care Physician's name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See Medical Emergency section for guidelines.

Aetna Member/Customer Services staff is ready to answer your questions. Here are some reasons you may need to call:

- Choosing your Primary Care Physician (PCP).
- Changing a new PCP.
- Asking questions about this plan.
- Reporting a lost or stolen ID card.
- Ordering a new ID card.
- Checking on the status of a referral or the status of approval.
- Asking about a claim.

You may call, write or visit Aetna about a claim.

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Member Services

Member Services Department

Customer service professionals (CSPs) are trained to answer your questions and to assist you in using the Plan properly and efficiently.

Call the Aetna Member Services toll-free number on your ID card (877-54-AETNA or 877-542-3862) to:

- Ask questions about benefits and coverage;
- Notify Aetna of changes in your name or telephone number;
- Change your PCP; or
- Notify Aetna about an emergency.

Contact Aetna Member Services at:
Blue Hen Corporate Center
655 South Bay Road
Suite 1-A
Dover, DE 19901

Please call your PCP's office directly with questions about appointments, hours of service or medical matters.

InteliHealth[®]

InteliHealth is Aetna's online health information affiliate. It was established in 1996 and is one of the most complete consumer health information networks ever assembled. Through this unique program, Plan participants have access, via the Internet, to the wisdom and experience of some of the world's top medical professionals in the field today. Access InteliHealth through the Aetna Internet website home page or directly via **www.intelihealth.com**.

Clinical Policy Bulletins

Aetna uses Clinical Policy Bulletins (CPBs) as a guide when making clinical determinations about health care coverage. CPBs are written on selected clinical issues, especially addressing new technologies, new treatment approaches, and procedures. The CPBs are posted on Aetna's website at **www.aetna.com**.

Aetna Navigator™

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from IntelliHealth®. Access Aetna Navigator™ through the Aetna website home page or directly **via** www.aetnavigators.com.

With Aetna Navigator, you can:

- Print instant eligibility information
- Request a replacement ID card
- Select a physician who participates in the Aetna network
- Check the status of a claim
- Link to a voluntary Health Risk Assessment tool
- Use the hospital comparison tool to compare hospital outcome information for medical care provided by hospitals in your area
- Estimate the cost of common health care services
- Receive personalized health and benefits messages
- Contact Aetna Member Services
- Find answers to common questions
- Change your PCP

Provider Information

You may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Aetna Member Services number on your ID card.

It is easy to obtain information about providers in Aetna's network using the Internet. With DocFind® you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind, go to www.aetna.com/docfind. Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation.

Your ID Card

When you join the Plan, you and each enrolled member of your family receive a member ID card. Your ID card lists the telephone number of the Aetna PCP you have chosen. If you change your PCP, you will automatically receive a new card displaying the change.

Always carry your ID card with you. It identifies you as a Plan participant when you receive services from participating providers or when you receive emergency services at nonparticipating facilities. If your card is lost or stolen, please notify Aetna immediately.

How the Plan Works

Members have access to a network of participating Primary Care Physicians (PCPs), specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

Each member of the Plan must select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system and will help you access appropriate care.

The Primary Care Physician

As a member of the Plan, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when medically necessary, your PCP will refer you to other doctors or facilities for treatment. The referral is important because it is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment. Except for PCP, direct access and emergency services, **you must have a prior written or electronic referral from your PCP to receive coverage for all services and any necessary follow-up treatment.**

Participating specialists are required to send reports back to your PCP to keep your PCP informed of any treatment plans ordered by the specialist.

Primary and Preventive Care

Your PCP can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP. You may also obtain routine vision exams and gynecological exams from participating providers without a referral from your PCP. You are responsible for the copayment shown in the "Copayment Schedule."

Specialty and Facility Care

Your PCP may refer you to a specialist or facility for treatment or for covered care services, when medically necessary. **Except for those benefits described in this Summary Plan Description as direct access benefits and emergency care, you must have a prior written or electronic referral from your PCP in order to receive coverage for any services the specialist or facility provides.**

When your PCP refers you to a participating specialist or facility for covered services, you will be responsible for the copayment shown in the "Copayment Schedule."

For inpatient expenses and surgery performed in an outpatient facility, you must pay a portion of the covered expenses you incur. Your share of covered expenses is called your **copay**.

To avoid costly and unnecessary bills, follow these steps:

- **Consult your PCP first** when you need routine medical care. If your PCP deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. Referrals are valid for 90 days, as long as you remain an eligible member in the Plan. For direct access benefits, you may contact the participating provider directly, without a referral.
- Certain services require **both** a referral from your PCP **and** prior authorization from Aetna. Your PCP is responsible for obtaining authorization from Aetna for in-network covered services.
- **Review the referral** with your PCP. Understand what specialist services are being recommended and why.
- Present the referral to the participating provider. Except for direct access benefits, any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services.**
- If it is not an emergency and you go to a doctor or facility **without your PCP's prior written or electronic referral, you must pay the bill yourself.**
- Your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by Aetna in addition to a special nonparticipating referral from your PCP. When properly authorized, these services are covered after the applicable copayment.

Remember: You cannot request referrals **after** you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from Aetna (when applicable) **before** seeking specialty or hospital care.

Some PCPs are affiliated with integrated delivery systems (IDS) or other provider groups (such as Independent Practice Associations and Physician-Hospital Associations). If your PCP participates in such an arrangement, you will usually be referred to specialists and hospitals within that system or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may ask to have services provided by non-affiliated physicians or facilities. Services provided by non-affiliated providers may require prior authorization from Aetna and/or the IDS or other provider group. Check with your PCP or call the Aetna Member Services number that appears on your ID card to find out if prior authorization is necessary.

Copayment Schedule

All non-emergency specialty and hospital services require a prior referral from your PCP, unless noted below as a “direct access” benefit.

Maximum Benefit	Unlimited per Plan participant per lifetime
Primary and Preventive Care	
PCP Office Visits	\$ 10 copay per visit
After Hours/Home Visits/Emergency Visits	\$ 25 copay per visit
Routine Examinations 1 visit per plan year	\$ 10 copay per visit
Routine Child and Well-Baby Care	\$ 10 copay per visit
Immunizations	\$ 10 copay per visit
Inpatient Visits	\$ 100 copay per day \$ 200 maximum per admission
Routine Gynecological Exams - direct access (no referral) to participating providers for 1 visit per plan year	\$ 10 copay per visit
Routine Mammogram - one annual mammogram for women age 40 and over	\$ 15 copay per visit
Prostate Screening - one annual prostate screening for men age 40 and over	\$ 0 copay per visit
Routine Eye Examinations 1 visit every 24 months	\$ 15 copay per visit
Hearing Exam by an Audiologist	\$ 20 copay per visit
Hearing Aids for children to age 18	20% copay. 3 hearing aids within 36 months (initial allowance, plus 1 replacement; 1 additional hearing aid if needed due to growth).
Specialty and Outpatient Care	
Specialist Office Visits	\$ 20 copay per visit
Prenatal Care - for the first OB visit	\$ 20 copay
Subsequent Prenatal Visits	\$ 0 copay
Infertility Services	Copay based on place of service. \$30,000 Lifetime Maximum
Advanced Reproductive Technology	Copay based on where service is provided
Allergy Testing	\$ 20 copay per visit
Allergy Treatment	\$ 5 copay per visit
X-rays and Lab Tests Performed at a Hospital Outpatient Facility	\$ 5 Laboratory copay per visit \$ 15 X-ray copay per visit \$ 20 Diagnostic Testing copay per visit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET) ; and other outpatient diagnostic imaging service.	\$ 25 copay

Outpatient Therapy (speech, occupational, physical) Occupational and Physical: Up to 45 visits per incident of illness or injury beginning with the first day of treatment. Speech Therapy: a separate 45 days per incident of illness or injury beginning with the first day of treatment.	80% (of the contracted rate) per visit
Chiropractic Care	\$ 20 copay per visit
Home Health Care	\$ 0 copay per visit
Hospice Care	\$ 0 copay per visit
Durable Medical Equipment (DME)	80% (of the cost) per item
DME Maximum Benefit	\$ 5,000 per individual, per plan year
Prosthetic Devices	No copay - some prostheses must be approved in advance by Aetna
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	\$ 100 copay per day \$ 200 copay maximum per admission
Skilled Nursing Facilities	\$ 0 copay admission (waived if transferred from a Hospital to a Skilled Nursing Facility)
Hospice Facility	\$ 0 copay per admission (waived if transferred from a Hospital to a Hospice Care facility)
Surgery and Anesthesia	
Inpatient Surgery	Subject to inpatient copay shown above
Outpatient Surgery: Performed at a Hospital Outpatient Facility	\$ 75 copay per visit
Performed at a facility other than a Hospital Outpatient Facility	\$ 30 copay per visit
Mental and Nervous Conditions	
Inpatient Treatment Serious Mental Illness	\$ 100 copay per day \$ 200 copay maximum per admission (See Inpatient visits)
Non-Serious Mental Illness Maximum of 30 days per plan year	20% copay
Outpatient Treatment Serious Mental Illness	\$ 20 copay per visit
Partial Hospitalization Maximum of 30 days per plan year Maximum of 2 visits per Lifetime	80%
Treatment of Alcohol and Drug Abuse	
Inpatient Detoxification	\$ 100 copay per day \$ 200 copay maximum per admission
Outpatient Detoxification	\$ 20 copay per visit

Maternity: Mother	\$ 100 copay per admission \$ 200 copay maximum per admission
Emergency Care	
Hospital Emergency Room or Outpatient Department	\$ 135 copay per visit. Waived if admitted
Urgent Care Facility	\$ 35 copay per visit
Ambulance	\$ 50 copay per trip
Prescription Drugs	Outpatient prescription drug coverage is administered by Medco. Refer to your Medco booklet describing the coverage available.

Your Benefits

Although a specific service may be listed as a covered benefit, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of your illness or condition. Refer to the “Glossary” section for the definition of “medically necessary.”

Certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval. If services are not precertified by Aetna, claims will not be paid.

Primary and Preventive Care

One of the Plan’s goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan (after any applicable copayment) if provided by your PCP or on referral from your PCP:

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your PCP.
- Well-child care from birth, including immunizations and booster doses, as recommended by your PCP.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Routine gynecological examinations and Pap smears performed by your PCP. You may also visit a participating gynecologist for a routine GYN exam and Pap smear without a referral.
- Annual mammography screening for asymptomatic women age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their PCP.

Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.

- Routine immunizations (except those required for travel or work).
- Periodic eye examinations
- Routine hearing screenings performed by your PCP as part of a routine physical examination.
- Lead screening test.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services. You must have a prior written or electronic referral from your PCP in order to receive coverage for any non-emergency services the specialist or facility provides.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see “In Case of Emergency”).

- Home health services provided by a participating home health care agency, including:
 - skilled nursing services provided or supervised by an RN.
 - services of a home health aide for skilled care.
 - medical social services provided or supervised by a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.
- Outpatient hospice services for a member who is terminally ill, including:
 - counseling and emotional support.
 - home visits by nurses and social workers.
 - pain management and symptom control.
 - instruction and supervision of a family member.

Note: The Plan does **not** cover the following hospice services:

- bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
 - homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
 - respite care when the patient's family or usual caretaker cannot, or will not, attend to the patient's needs.
- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, removal of tumors and orthodontogenic cysts).
 - Reconstructive breast surgery following a mastectomy, including:
 - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
 - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
 - physical therapy to treat the complications of the mastectomy, including lymphedema.
 - Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist.
 - Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Certain prosthetics require preauthorization by Aetna. Contact Aetna prior to placing order or making purchase to determine if preauthorization is required. Lack of preauthorization, if required, will result in claim being denied.
 - Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury, and preauthorized by Aetna.

The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:

- they are needed due to a change in your physical condition, or
- it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

The request for any type of DME must be made by your physician and coordinated through the Aetna Patient Management Department.

Infertility

- Infertility means for a female who is under age 45 who does not have the ability to conceive after six months without contraception or six cycles of artificial insemination. Infertility services are covered under your plan to diagnose and treat the underlying medical cause of infertility. You may obtain infertility services from a participating gynecologist or infertility specialist **without** a referral from your PCP. Infertility benefits are paid based on the provider and place of service identified in your "Schedule of Benefits". There's a \$30,000 lifetime payment limit. Charges are paid at the same benefit level as outpatient surgery. The \$30,000 limit applies even when you switch to another plan offered by the State of Delaware. If pregnancy results, your maternity benefits are then applied.
- Infertility services to diagnose and treat the underlying medical cause of infertility. You may obtain the following **basic** infertility services from a participating gynecologist or infertility specialist **without** a referral from your PCP:
 - initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
 - evaluation of ovulatory function,
 - ultrasound of ovaries at an appropriate participating radiology facility,
 - postcoital test,
 - hysterosalpingogram,
 - endometrial biopsy, and
 - hysteroscopy.

Semen analysis at an appropriate participating laboratory is covered for male Plan participants; a **referral** from your PCP is necessary.

-If you do not conceive after receiving the above infertility services, or if the diagnosis suggests that there is no reasonable chance of pregnancy as a result of the above services, you are eligible to receive the following **comprehensive** services through a participating infertility specialist **when preauthorized through and coordinated by the Aetna Infertility Unit**:

- ovulation induction cycles (bloodwork and ultrasounds), subject to a lifetime maximum of 6 cycles;
 - artificial insemination, subject to a lifetime maximum of 6 attempts, and
 - advanced reproductive technology (ART).
- Coverage for advanced reproductive technology (ART) is limited to:
 - no more than 3 cycles per lifetime for all ART services and treatment, including in vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT) and cryopreserved embryo transfer.
 - charges associated with your care when participating in a donor IVF program, including fertilization and culture.
 - charges associated with obtaining your partner's sperm for ART, when your partner is also covered under this Plan.

To receive coverage for advanced reproductive technology, you must:

- obtain a referral from your PCP or participating gynecologist or contact an Infertility Unit case manager at the Aetna Member Services number shown on your ID card,
- undergo an initial evaluation and consultation with, and be recommended for, ART treatment by a participating ART specialist, and
- obtain preauthorization through the Infertility Unit, either directly or through your ART specialist.

The following expenses are not covered:

- ART services when either the male or female partner has undergone a sterilization procedure in the past.
- ART services for females with FSH levels greater than 19 mIU/ml on day 3 of the menstrual cycle.
- ART services for females without a male partner who have not had at least 12 cycles of donor insemination prior to enrolling in the Infertility Program (6 cycles for females age 35 or older).
- ART services that are not reasonably likely to result in success.

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice

If you are hospitalized by a participating PCP or specialist (with prior referral except in emergencies), you receive the benefits listed below. See “Behavioral Health” for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your PCP) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Intensive or special care facilities.
- Visits by your PCP while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
 - cardiac rehabilitation, and
 - pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic resonance imaging.
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Maternity

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may – **after consulting with you** – discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

You do not need a referral from your PCP for visits to your participating obstetrician. A list of participating obstetricians can be found in your provider directory or on DocFind (see “Provider Information”).

Note: Your participating obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care after your first visit. They must request approval (precertification) for any tests performed outside of their office and for visits to other specialists. Please verify that the necessary referral has been obtained before receiving such services.

If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers **on and after your effective date**. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Transplant Expenses

Once it has been determined that you or one of your dependents may require an organ transplant, you, or your **physician** should call the Aetna precertification department to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements found in the Certification for Admissions sections of this document. Organ means solid organ; stem cell; bone marrow; and tissue.

Benefits may vary if an **Institute of Excellence (IOE)** facility or non-**IOE** is used. In addition, some expenses listed below are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered as preferred care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a preferred facility for other types of services, will be covered at the non-preferred level. Please read each section carefully.

Covered Transplant Expenses

Covered transplant expenses include the following:

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parent, sibling or child.
- Inpatient and outpatient expenses directly related to a transplant.
- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility **or physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

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

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

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

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

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell transplant
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)

- Sequential transplants
- Re-transplant of same organ type within 189 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

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

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

Limitations

The transplant coverage does not include charges for:

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

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. You do not need a referral from your PCP to obtain care from participating mental health and substance abuse providers. Instead, when you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Mental Health Treatment

The Plan covers the following services for mental health treatment:

- **Inpatient** medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.
- Short-term evaluation and crisis intervention mental health services provided on an **outpatient** basis.

Treatment of Alcohol and Drug Abuse

The Plan covers the following services for treatment of alcohol and drug abuse:

- **Inpatient** care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- **Inpatient** medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an appropriately licensed facility.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your PCP.
- **Outpatient** visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.

Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

Prescription Drugs

The Plan covers only prescription drugs administered while you are an inpatient in a covered health care facility, administered in a doctor's office, or through home infusion. Prescription drugs, if your doctor writes you a prescription, are covered through the State of Delaware's prescription benefit manager.

Please refer to the separate booklet describing the outpatient prescription drug coverage available through Medco.

Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by The Plan.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
 - reconstructive surgery to correct the results of an injury.
 - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
 - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
- Custodial care and rest cures.
- Dental care and treatment, except as specified under "Your Benefits". The Plan does not cover:
 - care, filling, removal or replacement of teeth,
 - dental services related to the gums,
 - apicoectomy (dental root resection),
 - orthodontics,
 - root canal treatment,
 - soft tissue impactions,
 - alveolectomy,
 - augmentation and vestibuloplasty treatment of periodontal disease,
 - prosthetic restoration of dental implants, and
 - dental implants.
- Drugs and medicines which by law need a physician's prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.
- Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.

This exclusion will not apply to drugs:

 - that have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
 - that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
 - that Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.

Refer to the "Glossary" for a definition of "experimental or investigational."
- False teeth.

- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids, eyeglasses, or contact lenses or the fitting thereof, except as specified in the "Copayment Schedule".
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work.
- Implantable drugs
- Infertility services, except as described under "Your Benefits." The Plan does not cover:
 - purchase of donor sperm and any charges for the storage of sperm.
 - purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
 - cryopreservation and storage of cryopreserved embryos.
 - all charges associated with a gestational carrier program (surrogate parenting) for the Plan participant or the gestational carrier.
 - drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
 - injectable infertility drugs.
 - the costs for home ovulation prediction kits.
 - services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.
 - services for females with FSH levels greater than 19 mIU/ml on day 3 of the menstrual cycle.
- Oral and implantable contraceptive drugs and devices, except when prescribed to treat certain medical conditions.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips,
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Private duty or special nursing care.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
 - obtaining or continuing employment,
 - obtaining or maintaining any license issued by a municipality, state or federal government,
 - securing insurance coverage,
 - travel, and
 - school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.
- Services and supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.

- Specific injectable drugs, including:
 - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health, injectable drugs not considered medically necessary or used for cosmetic, performance, or enhancement purposes, or not specifically covered under this plan,
 - drugs related to treatments not covered by the Plan, and
 - drugs related to the treatment of infertility, contraception, and performance-enhancing steroids.
- Specific non-standard allergy services and supplies, including (but not limited to):
 - skin titration (rinkel method),
 - cytotoxicity testing (Bryan's Test),
 - treatment of non-specific candida sensitivity, and
 - urine autoinjections.
- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):
 - primal therapy.
 - chelation therapy.
 - rolfing.
 - psychodrama.
 - megavitamin therapy.
 - purging.
 - bioenergetic therapy.
 - vision perception training.
 - carbon dioxide therapy.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under "Your Benefits."
- Treatment of occupational injuries and occupational diseases, including injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does. If you are covered under a Workers' Compensation law or similar law, and submit proof that you are not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational," regardless of cause.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
 - treatment performed by placing a prosthesis directly on the teeth,
 - surgical and non-surgical medical and dental services, and
 - diagnostic or therapeutic services related to TMJ.
- Weight reduction programs and dietary supplements.

Limitations

In the event there are two or more alternative medical services that, in the judgment of Aetna, are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance.

In Case of Medical Emergency

Guidelines

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Aetna has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
- *Serious impairment to bodily function; or*
- *Serious dysfunction of any bodily organ or part.*

Some examples of emergencies are:

- Heart attack or suspected heart attack.
- Poisoning.
- Severe shortness of breath.
- Uncontrolled or severe bleeding.
- Suspected overdose of medication.
- Severe burns.
- High fever (especially in infants).
- Loss of consciousness.

Whether you are in or out of Aetna's service area, we ask that you follow the guidelines below when you believe you may need emergency care.

1. Call your PCP first, if possible. Your PCP is required to provide urgent care and emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility, or dial 911 or your local emergency response service.
2. After assessing and stabilizing your condition, the emergency facility should contact your PCP so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible. The emergency room copayment will be waived if you are admitted to the hospital.
4. All follow-up care must be coordinated by your PCP.
5. If you go to an emergency facility for treatment that Aetna determines is non-emergency in nature, you will be responsible for the bill. The Plan does not cover non-emergency use of the emergency room.

Follow-Up Care After Emergencies

All follow-up care should be coordinated by your PCP. You must have a referral from your PCP **and** approval from Aetna to receive follow-up care from a nonparticipating provider. Whether you were treated inside or outside your Aetna service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit;
- You could not reasonably have anticipated the need for the care prior to leaving the network service area; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Urgent care from participating providers within your service area is covered if your PCP is not reasonably available to provide services to you. You should first seek care through your PCP. Referrals to participating urgent care providers are not required, but the care must be urgent, non-preventive or non-routine.

Some examples of urgent medical conditions are:

- Severe vomiting.
- Earaches.
- Sore throat.
- Fever.

Follow-up care provided by your PCP is covered, subject to the office visit copayment. Other follow-up care by participating specialists is fully covered with a **prior written or electronic referral** from your PCP, subject to the specialist copay shown in the “Copayment Schedule.”

What to Do Outside Your Aetna Service Area

Members who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, or an urgent care center. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings. You should call your PCP before receiving treatment from a non-participating urgent care provider.

If, after reviewing information submitted to Aetna by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an Emergency Room Notification Report or a customer service professional (CSP) can take this information over the telephone.

Special Programs

Alternative Health Care Programs

Natural Alternatives* - If you are interested in alternative therapies such as acupuncture or massage therapy, Aetna has a program to meet your needs. Aetna's Natural Alternatives program offers you special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapists and nutritional counselors.

Vitamin Advantage™ - You can save on vitamins and nutritional supplements purchased through mail order, over the phone, by fax, or over the Internet.

Natural Products - You also can save on many health-related products, including aromatherapy, foot care and natural body care products.

You may place orders by mail, telephone, fax or Internet to receive savings on health-related products offered through these programs.

To Find Out More - Call the Member Services number on your ID card, or visit Aetna on the web at http://www.aetna.com/products/natural_alt_99.html. There you can find a listing of participating providers, vendors and the latest additions to the product list. Visit the website often — these programs are growing!

*Natural Alternatives is not available in all states.

Fitness Program

Aetna offers Plan participants access to discounted fitness services provided by GlobalFit™. Plan participants can join the GlobalFit network and receive discounts on their health club membership rate. The Fitness Program offers Plan participants:

- Low or discounted membership rates at independent health clubs contracted with GlobalFit;
- Free guest passes to allow you to sample facilities before selecting a club* to join;
- Guest privileges at other participating GlobalFit health clubs,* and
- Discounts on certain home exercise equipment.

* *Not available at all clubs.*

To view a list of included clubs, visit the GlobalFit website at www.globalfit.com/fitness. If you would like to speak with a GlobalFit representative, you can call GlobalFit at 1-800-298-7800.

Aetna Health ConnectionsSM Disease Management Program

Aetna's ongoing commitment to improve care for all members includes the Aetna Health ConnectionsSM Disease Management program which expands the availability of medical management programs to all members, regardless of their health status, who may be at risk for high cost or gaps in care. While traditional disease management programs focus on delivering education to at-risk members about a specific chronic condition, the Aetna Health ConnectionsSM Disease Management program enhances such medical management services by including:

- Enhanced Case Management Services
- Enhanced wellness offerings
- Broadened disease management programs which consider multiple diseases or conditions (among them 30 vascular, pulmonary, orthopedic, neurological, and gastroenterological conditions) and deliver individualized programs based on each member's unique needs and preferences.

Aetna Health ConnectionsSM Disease Management program will continue to proactively identify members with (or who are at risk for) established medical conditions while expanding its focus by delivering comprehensive support services for the significant number of people who present with more than one chronic or recurring condition. Regardless of their health status, Aetna's programs and web-based tools are designed to help members become more informed health consumers, more aware of their own health status, and more engaged in taking action to improve or maintain their health.

Member Health Education Programs

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, Aetna's innovative Member Health Education Programs offer health education, preventive care and wellness programs to Plan participants. These programs provide materials that, in conjunction with care and advice from a physician, help promote a healthy lifestyle and good health.

To obtain information on Member Health Education Programs, call the toll-free number on your ID card or visit http://www.aetna.com/products/health_education.html.

Childhood Immunization Program

Children need immunizations to protect them from a number of dangerous childhood diseases that could have very serious complications. Vaccines have been proven to be powerful tools for preventing certain diseases. It has been shown over time that the risks of serious illness from not vaccinating children far outweigh any risk of reaction to immunization. The common childhood diseases that vaccinations can guard against are:

- Measles
- Mumps
- Rubella
- Polio
- Pertussis (whooping cough)
- Diphtheria
- Tetanus
- Haemophilus influenzae type B
- Hepatitis B
- Varicella (chicken pox)

To promote good health through prevention, the Childhood Immunization Program sends immunization reminders to parents of children covered under this Plan.

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. This reminder contains a list of immunizations recommended at 18 months. * The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing immunizations.

If you have questions about specific vaccinations, please call your pediatrician or your family doctor.

** Source: Office of Prevention and Health Promotion, in cooperation with the agencies of Public Health Services, U.S. Department of Health and Human Services. Center for Disease Control and Prevention (CDC), American Association of Pediatrics (AAP), and Advisory Committee on Immunization Practices.*

Adolescent Immunization

Adolescents need to see their doctors regularly for physical exams and screenings and to update immunizations. To reinforce the importance of protecting their children's health, parents of all 11- and 12-year-olds are sent a newsletter that includes examination and immunization schedule recommended for these age groups. This reminder is in the form of a newsletter provided by Merck & Co., Inc.

Preventive Reminders

Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats. Each year, Aetna sends a preventive health care reminder to households with a member who is particularly vulnerable to one or more of these diseases – adults who are age 50 and older, children ages 6-23 months, and people over age 2 with a chronic condition such as asthma, congestive heart failure, or chronic renal failure.

The reminder stresses the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screening.

Cancer Screening Programs

Early detection and treatment is important in helping our members lead longer, healthier lives. Member Health Education provides members with an important means of early detection.

Breast Cancer Screening

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease. The mailer may also include information on participating mammography centers or information for women who have chosen a primary care physician with a capitated radiology office.

Cervical

Gynecological examinations and Pap smears are vital to women's health because they are often the first step in the detection and treatment of abnormalities. This program reminds female members, starting at 18 years of age, to get exams and Pap smears on a regular basis. Annually, female members are sent information stressing the importance of annual gynecological exams, direct access to care, as well as instructions on how to perform breast self-examination.

Colorectal

The colorectal cancer cure rate can exceed 80 percent when detected early. We encourage you to discuss questions about colorectal cancer screening with your physician. Together you and your physician can choose the most appropriate method of colorectal cancer screening. Aetna sends annual reminders stressing the importance of completing appropriate colorectal cancer screening.

Healthy Insights Member Newsletter

Aetna periodically publishes the *Healthy Insights* newsletter. The newsletter features health-related information, education about various benefits and issues important to quality management and patient management. *Healthy Insights* is an important resource that communicates with Plan participants about a wide variety of topics.

Informed Health® Line

Informed Health® Line provides eligible Plan participants with telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses encourage informed health care decision making and optimal patient/provider relationships through information and support. However, the nurses do not diagnose, prescribe or give medical advice.

Informed Health Line is available to eligible employees and their families virtually 24 hours per day, 365 days per year from anywhere in the nation by calling 1-800-556-1555.

Backed by the Healthwise® Knowledgebase™ (a computerized database of over 1900 of the most common health problems) and an array of other online and desk references, the nurses help you understand health issues, treatment options, review specific questions to ask your provider, provide research analyses of treatments and diagnostic procedures, and explain the risks and benefits of various options. The nurses encourage patient/provider interaction by coaching you to give a clear medical history and information to providers and to ask clarifying questions.

Numbers-to-Know™ -- Hypertension and Cholesterol Management

Aetna created *Numbers To Know*™ to promote blood pressure and cholesterol monitoring. The *Numbers To Know* mailer is sent to Plan participants who are targeted by selected diagnoses within specific age groups. The mailer includes helpful tips on blood pressure and cholesterol management; desirable goals for blood pressure and cholesterol; and a tri-fold wallet card to track blood pressure, total cholesterol, medication and dosage information.

Hypertension and high cholesterol are never "cured" but may be controlled with lifestyle changes and adherence to a treatment plan. You can help to stay "heart healthy" by monitoring your blood pressure and blood cholesterol numbers.

Numbers To Know can help encourage you to understand your illness, monitor your high blood pressure and high cholesterol and work with your physician to develop an appropriate treatment plan.

Vision One® Discount Program

Plan participants are eligible to receive discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions through the Vision One program at thousands of locations nationwide. Just call 1-800-793-8616 for information and the location nearest you.

Plan participants are also eligible to receive a discount off the provider's usual retail charge for Lasik surgery (the laser vision corrective procedure) offered by Cole/LCA-Vision LLC through the national Lasik network of LCA Vision, Inc. Included in the discounted price is patient education, an initial screening, the Lasik procedure and follow-up care. To find the closest surgeons, call 1-800-422-6600 and speak to a Lasik customer service representative.

Vision One is a registered trademark of Cole Vision.

Women's Health Care

Aetna is focused on the unique health care needs of women. They have designed a variety of benefits and programs to promote good health throughout each distinct life stage, and are committed to educating female Plan participants about the lifelong benefits of preventive health care.

Support for Women With Breast Cancer

Aetna's Breast Health Education Center helps women make informed choices when they've been newly-diagnosed with breast cancer. A dedicated breast cancer nurse consultant provides the following services:

- Breast cancer information
- Second opinion options
- Information about community resources
- Benefit eligibility
- Help with accessing participating providers for:
 - Wigs
 - Lymphedema pumps

Call 1-888-322-8742 to reach Aetna's Breast Health Education Center.

Confidential Genetic Testing for Breast and Ovarian Cancers

Aetna covers confidential genetic testing for Plan participants who have never had breast or ovarian cancer, but have a strong familial history of the disease. Screening test results are reported directly to the provider who ordered the test.

Direct Access for OB/GYN Visits

This program allows a female Plan participant to visit any participating gynecologist for one routine well-woman exam (including a Pap smear) per year, without a referral from her PCP. The Plan also covers additional visits for treatment of gynecological problems and follow-up care, without a PCP referral. Participating general gynecologists may also refer a woman directly for appropriate gynecological services without the patient having to go back to her participating PCP.

If your gynecologist is affiliated with an IDS or provider group, such as an independent practice association (IPA), you may be required to coordinate your care through that IDS or provider group.

Infertility Case Management and Education

Infertility treatment can be an emotional experience for couples. Aetna's infertility case management unit provides Plan participants with educational materials and assistance with coordinating covered infertility care. A dedicated team of registered nurses and infertility coordinators staffs the unit.

Moms-to-Babies Maternity Management Program™

The Moms-to-Babies™ maternity management program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Educational materials on prenatal care, labor and delivery, postpartum depression and breastfeeding
- Specialized information for Dad or partner
- Web-based materials and access to program services through Women's Health Online
- Care coordination by trained obstetrical nurses
- Access to Smoke-free Moms-to-be® smoking cessation program for pregnant women
- Preterm labor education
- Access to breastfeeding support services

Under the program, all care during your pregnancy is coordinated by your participating obstetrical care provider and Moms-to-Babies case managers, so there is no need to return to your PCP for referrals. However, your obstetrician will need to request a referral from Aetna for any tests performed outside of the office. To ensure that you are covered, please make sure your obstetrician has obtained this referral before the tests are performed.

Another important feature, ***Pregnancy Risk Assessment***, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

Eligibility

Who Can Be Covered

Your plan may cover:

- You;
- Your spouse;
- Your unmarried children.

NOTE: The State of Delaware requires proof of dependency; Aetna will require proof of disability.

Types of Enrollment

You may enroll in one of these coverage types:

- Employee for you only;
- Employee and Child (ren) for you and your family;
- Employee and Spouse for you and your spouse; or,
- Family for you, your spouse and your children.

You Are Eligible To Be Covered If:

- you are a regular officer or employee of the State;
- you are a regular officer or employee of a State agency or school district;
- you are a pensioner already receiving a State pension;
- you are a per diem and contractual employee of the Delaware General Assembly and have been continuously employed for 5 or more years;
- you are regularly scheduled full-time employee of any Delaware authority or commission participating in the State's Group health Insurance Program;
- you are a regularly scheduled full-time employee of the Delaware Stadium Corporation or the Delaware Riverfront Corporation;
- you are a paid employee of any volunteer fire or volunteer ambulance company participating in the State's Group Health Insurance program;
- you are a regularly scheduled full-time employee of any county, soil and water conservation district or municipality participating in the Group Health Insurance program;
- you are receiving or eligible to receive retirement benefits in accordance with the Delaware County and Municipal Police/Firefighter Pension Plan with Chapter 88 of Title 11 of the Delaware Code or the county and municipal pension plan under Chapter 55A of Title 29 of the Delaware Code.

Children

To be covered, a child must be:

- unmarried;
- under age 21; and,
- either:
 - born to you or your spouse;
 - adopted by you or your spouse;
 - placed in your home for adoption; or,
 - living in your home in a parent/child relationship (however, if the child's parent also lives in your home, the child is not eligible for coverage).

The State of Delaware requires proof of dependency when submitting application for coverage.

Full-time Students

Full-time Students can be covered up to age 24. You must submit a *Student Certification Form* each year to receive coverage. You may contact Aetna to obtain a form.

The child must take a minimum of 12 credit hours every semester. However, only 9 credit hours are necessary if the student is in the semester before graduation. A student nurse must be enrolled in a degree program.

The school must have:

- a regular facility;
- a set curriculum; and,
- a regular student body attending.

The school may be a:

- prep school;
- junior college;
- seminary; or,
- university.

Disabled Children

Disabled children can be covered after age 21 (or age 24 for students). They may be covered if:

- they were covered by a health plan before reaching age 21 (or age 24 for students);
- they are not married;
- they cannot support themselves because of a disability;
- their disability happened before age 21 (or age 24 for students); and,
- they depend on you for support.

You must file a *Disabled Child Application* form with Aetna who can also provide you with the form.

The Adult Dependent Program

The Adult Dependent Program is designed to provide health care coverage to an employee's or a pensioner's adult dependent child(ren), biologically or by law, who meet(s) all of the following eligibility requirements. The adult dependent must:

- be less than 24 years of age;
- be unmarried;
- have no dependents of his/her own;
- be either a resident of the State of Delaware or enrolled as a full-time student at an accredited institution of higher learning; and,
- not be provided coverage as a named subscriber, insured, enrollee or covered person under any other group or individual health benefits plan, group health plan, or church plan, or entitled to benefits under Medicare.

Members who enroll in the Adult Dependent Program are not eligible for some services described in this Summary Plan Description. Additionally, enrollment and appeal rights are different. These differences will be clarified for those members enrolling in the program.

Contact Aetna's Member/Customer Service area for more information about the Adult Dependent Program.

Medicare Eligibility

At age 65 you become eligible for Medicare. Medicare is provided by the Federal Government. It is not part of this health care plan.

If you are an active employee working at age 65, you have a choice of benefit plans:

- you can continue coverage in this plan until your retire. This plan will be primary.
- or, you can be covered under Medicare. Medicare will be primary. You won't have any other coverage through the State. You may be able to purchase secondary coverage directly through an insurance company.

About three months before you reach age 65, contact:

- your Human Resources Office, and,
- Social Security Administration Office

Follow the same guidelines when your spouse reaches age 65.

You have to be an active, full-time employee to be covered under this plan when you reach age 65 for your spouse to be covered under this plan when he or she reaches age 65.

Enrollment

Enrollment Date

Your enrollment date is the later of:

- your date of hire for Timely Enrollees (if you're in an employee class eligible for health coverage);
- the date you move to an employee class that is eligible for health coverage (such as going from part-time to full-time employee); or,
- the date coverage begins if you're a Special Enrollee or a Late Enrollee.

How To Enroll

You may enroll yourself and your dependents when you are first eligible or at open enrollment by completing an enrollment form/application and returning it to your Human Resources/Benefits Office (with any premium owed). If you want to cover your spouse, you'll need to complete the *Spousal Coordination of Benefits Form*. You can get both the enrollment form/application and Spousal COB form from your Human Resources/Benefits Office

When Coverage Begins

When your coverage begins is determined by:

- when you are eligible for coverage; and,
- when you enroll for coverage.

There are three categories of enrollees based on when you enroll for coverage. You can be a:

- Timely Enrollee;
- Special Enrollee; or,
- Late Enrollee.

Timely Enrollees

Who Can be a Timely Enrollee

You are a Timely Enrollee if you enroll within 30 days of when you are first eligible to be covered.

When Coverage Begins

Coverage for new employees (and their dependents) begins:

- on the first of the month following the employee's hire date; or,
- on the first of the month following the date of enrollment when an employee moves to a class that is eligible for health coverage.

Special Enrollees

Who Can Be A Special Enrollee

You are a Special Enrollee if you request enrollment within the 30-day enrollment period. The enrollment period is within 30 days of:

- losing other health coverage under certain conditions;
- obtaining a new dependent because of marriage, birth (enrollment period is 31 days, see section below entitled Changes in Enrollment, Newborns), adoption, or placement in the home for adoption, or court ordered support.

Employees or dependents may qualify as Special Enrollees if the following requirements are met:

- Employees: if you're not already enrolled in this plan, you must:
 - be eligible to enroll in this plan; and,
 - enroll at the same time you enroll a dependent.
- Spouses and Children: you're a dependent of an employee:
 - who is already enrolled or is eligible to enroll in this plan; and,
 - who enrolls at the same time you enroll.

If you don't request enrollment within the 30-day enrollment period, you are a Late Enrollee.

Loss Of Other Coverage

To qualify as a Special Enrollee because of loss of coverage, you (the employee or dependent) must meet all these conditions:

- you were covered under another group or individual health plan when coverage was previously offered under this plan (when first eligible or during open enrollment);
- when this plan was previously offered, you declined coverage under this plan because you had other coverage; and,
- the other coverage was either:
 - COBRA continuation coverage that is exhausted; or,
 - other (non-COBRA) coverage that was lost because:
 - you are no longer eligible;
 - the employer stopped contributing; and,
 - you request enrollment within 30 days of the date
 - COBRA continuation coverage that is exhausted; or,
 - the other (non-COBRA) coverage that was lost because:
 - you lost eligibility; or,
 - the employer stopped contributing, and,
- you can prove the loss of the other coverage by providing proof of coverage, such as a *Certificate of Coverage*.

New Dependents

You (employee or dependent) are a Special Enrollee if the employee gets a new dependent because of:

- a marriage;
- birth;
- adoption;
- placement of a child in the home for adoption; or,
- court ordered support.

When Coverage Begins

Coverage for Special Enrollees begins as follows if the Human Resources/Benefits Office was notified of a loss of coverage or new dependent within 30 days and your application and premium is subsequently submitted:

- *Employees*: the first day of the month after the loss of coverage.
- *Spouses*: either the date of the marriage or the first day of the month after the marriage.
- *Children*: either:
 - the date of birth, adoption or placement in the home for adoption;
 - the first day of the month after you request enrollment if:
 - you lost coverage under a prior plan; or,
 - your parents got married.

Remember, if you enroll after the 30-day enrollment period, you (and your dependents) will be Late Enrollees.

Don't forget, when you get married and add your spouse, you'll also need to complete the *Spousal Coordination of Benefits Form* and provide copy of your Marriage Certificate.

Late Enrollees

Who Can Be A Late Enrollee

If you did not enroll as a Timely or Special Enrollee, you are a Late Enrollee. Late Enrollees can enroll at an open enrollment period.

Children are Late Enrollees if enrollment was not requested within 30 days of:

- birth (31 days);
- adoption; or,
- placement in the home for adoption

When Coverage Begins

Coverage for Late Enrollees begins the first day of the new plan year.

Changes In Enrollment

You can change your enrollment because of one of the reasons described below.

Marriage

You may add your spouse when you get married. You must request enrollment within 30 days after the marriage. If added premium is due, you must pay when you request enrollment. If you request enrollment within the 30-day period, your spouse will be a Special Enrollee. If you don't request enrollment within the 30-day period, your spouse will be a Late Enrollee.

Don't forget, when you get married you'll also need to complete the *Spousal Coordination of Benefits Form* and **provide a copy of your marriage certificate to your Human Resources/Benefits Office.**

Newborns

You may add your newborn child. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. Hospital nursery care is covered for infants when the mother is having hospital obstetrical care. If a sick infant must stay in the hospital, the baby remains covered for the first 31 days after the infant's birth. There is no coverage after those 31 days unless:

- You have coverage that already covers dependent children. You must request enrollment for the child within 31 days of the child's birth.
- You have coverage that doesn't cover dependent children and you request enrollment for coverage that includes children. You must request enrollment for the child within 31 days of the child's birth. If added premium is due, you must pay it when you enroll.

If you request enrollment within the 31-day period, the newborn will be a Special Enrollee. If you don't request enrollment within the 31-day period, the child will be a Late Enrollee.

Adopted Children

You may add a child because of adoption or placement in your home for adoption. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. You must request enrollment within 30 days of the date of adoption or placement in the home in order for the child to be a Special Enrollee. If you don't request enrollment within the 30-day period, the child will be a Late Enrollee.

Other Children

You may add a child other than a newborn or adopted child, such as a stepchild. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. You must request enrollment for your child within 30 days of the date the child became eligible in order to be a Special Enrollee. If you don't request enrollment within the 30-day period, the child will be a Late Enrollee.

When Continuation of Coverage Under COBRA Ends

You may have declined coverage under this plan when you were first eligible because you chose to keep COBRA coverage with another plan. If you enroll in this plan before your COBRA continuation coverage is exhausted, you will be a Late Enrollee.

When your COBRA continuation coverage is exhausted, you may request enrollment in this plan within 30 days. If you request enrollment within the 30-day period, you will be a Special Enrollee. If you don't request enrollment within the 30-day period, you will be a Late Enrollee.

When Coverage Ends

The State of Delaware COBRA Administrator will provide you and your dependents with a standard *Certificate of Coverage* when you lose coverage under this plan. Also, you have up to 24 months following the loss of coverage to request a certificate. The *Certificate of Coverage* will show how long you were covered under this plan. Except in cases of divorce or a change in a child's status (see section below regarding each), coverage ends the last day of the month in which you lose eligibility because of one of the events below.

Divorce

Former spouses are not eligible for coverage under this program. You must notify your Human Resources/Benefits Office of the divorce and provide them with a copy of your divorce decree. An enrollment form/application must be completed within 30 days of the divorce. State "divorce" as the reason for the change. Coverage ends on the date of the divorce.

Leave Your Job

Coverage ends at the end of the month in which you leave your job.

Death

Coverage ends for your dependents at the end of the month in which you die, except for dependents of pensioners. Coverage for dependents of pensioners ends either:

- the last day of the month of your death;
- if contributions have already been made, the last day of the following month; or,
- when the dependent no longer meets eligibility conditions

Change in Your Job Status

Coverage ends when you're no longer eligible through your job. This might happen if you begin to work fewer hours, etc. Please refer to the section, *You Are Eligible To Be Covered If*, above.

Change in Child's Status

Your child's coverage ends the earlier of:

- December 31 of the year the child reaches age 21;
- when the child marries;
- the end of the month that the child is no longer a full-time student (such as when he or she graduates); or,
- the end of the month in which a full-time student reaches age 24.

The Plan is Canceled

Coverage ends the day the State of Delaware's contract with Aetna ends.

Benefits After Your Coverage Ends

All benefits end when you lose coverage, except:

- if the State of Delaware cancels the plan; and,
- if you are an inpatient on the date the plan ends.

You're covered for the care you receive as an inpatient. The plan covers you through the earlier of:

- 10 days after the plan ends, or,
- until you are discharged.

Continuing Your Coverage Under COBRA

You may continue your coverage after you lose coverage under this plan. This right is provided under a law called the Consolidated Omnibus Budget Reconciliation Act (COBRA). If you decide to continue your coverage, you will have to pay up to 102% of the cost of coverage.

The following is a brief explanation of the law:

Employee

You (and your dependents) can continue coverage for up to 18 months if you lose group coverage because:

- your hours at work are reduced; or,
- your job ends (for reasons other than gross misconduct).

You, the employee, can continue coverage beyond 18 months if you:

- are disabled when you become eligible for COBRA coverage; and,
- are considered disabled under Social Security.

You are then entitled to an additional 11 months (totaling 29 months). Your cost would be 150% of the plan cost for months 19 through 29.

Spouse of Employee

Your spouse can continue coverage for up to 36 months if coverage ends because:

- you die;
- you divorce from your spouse; or,
- you become eligible for Medicare.

Dependent Child of Employee

A child can continue coverage for up to 36 months if coverage ends because:

- you die;
- you and your spouse are divorces or legally separated;
- you become eligible for Medicare; or,
- the child is no longer considered a dependent under this plan.

Notifying the State

You need to let your Human Resources/Benefits Office know within 30 days of:

- a divorce;
- a child losing dependent status; or,
- disability determination by Social Security

Notify your Human Resources/Benefits Office within 30 days if Social Security determines you are no longer disabled. After you notify your Human Resources/Benefits Office or the State of Delaware's COBRA Administrator, you will be sent information about COBRA and how much it costs. You can choose to continue coverage under COBRA. If you do, then you have the right to the same coverage as the active employees. If you don't, your coverage under this plan ends. You should contact State of Delaware's COBRA Administrator if you have any questions.

When Your Coverage Under COBRA Ends

You can lose the coverage you continued under COBRA if:

- the State of Delaware no longer has any group health coverage;
- you don't pay the premium on time;
- you become eligible for Medicare or,
- you get coverage under another group plan. An exception may apply if the other plan:
 - has a preexisting condition waiting period; and,
 - provides credit for prior creditable coverage to offset the preexisting condition waiting period.

In such cases, you can be covered under both plans.

You are eligible to receive a standard *Certificate of Coverage* after you lose coverage under COBRA.

Termination for Cause

A Plan participant's coverage may be terminated for cause. "For cause" is defined as:

- **Failure to make copayments:** You or a member of your family fails to make any required copayment or any other payment that you are obligated to pay.
- **Furnishing incorrect or incomplete information:** You or a member of your family willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in, or obtaining benefits from, the Plan. Termination will be effective immediately.
- **Fraud against the Plan:** This may include, but is not limited to, allowing a person who is not a participant of the Plan to use your Aetna ID card. Termination will be effective immediately.
- **Misconduct:** You or a covered member of your family abuses the system, including (but not limited to) theft, damage to the property of a participating provider, or forgery of drug prescriptions. Termination will be effective immediately.

No benefits will be provided to you and your family members once coverage is terminated.

Any termination for cause is subject to review in accordance with the Plan's grievance process. You may request that Aetna conduct a grievance hearing within 15 working days after receiving notice that coverage has been or will be terminated. Coverage will be continued until a final decision on the grievance is rendered, provided you continue to make required contributions. Termination may be retroactive to the original date of termination if the final decision is in favor of Aetna.

Family and Medical Leave

If your employer grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by your employer to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, your employer may recover from you the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is terminated because of your gross misconduct, you will not be eligible for COBRA continued coverage.

Portability of Coverage

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your employer will give you a certificate confirming your participation in the Plan when your employment terminates. Certificates can be requested from your Human Resources/Benefits Representative.

Claim Procedures

A claim occurs whenever a member requests:

- An authorization or referral from a participating provider or Aetna; or
- Payment for items or services received.

Because you are a participant in an HMO-type plan, you do not need to submit a claim for most of your covered healthcare expenses. However, if you receive a bill for covered services, the bill must be submitted promptly to Aetna for payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card.

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

Adverse benefit determinations are decisions Aetna makes that result in denial, reduction, or termination of a benefit or the amount paid for it. 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;
 - a Plan limitation has been reached; or,
 - it is not medically necessary.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown below. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see “Complaints and Appeals” for more information about appeals.

Type of Claim	Response Time
<p>Urgent care claim: a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment. 	As soon as possible but not later than 72 hours.
<p>Pre-service claim: a claim for a benefit that requires Aetna’s approval of the benefit in advance of obtaining medical care.</p>	15 calendar days
<p>Concurrent care claim extension: a request to extend a previously approved course of treatment.</p>	<p>Urgent care claim - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment</p> <p>Other claims - 15 calendar days</p>
<p>Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.</p>	With enough advance notice to allow the Plan participant to appeal
<p>Post-service claim: a claim for a benefit that is not a pre-service claim.</p>	30 calendar days

Extensions of Time Frames

The time periods described in the chart may be extended.

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

For non-urgent pre-service and post-service claims: The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

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

Grievances and Appeals

The Plan has procedures for you to follow if you are dissatisfied with a decision that Aetna has made or with the operation of the Plan. The process depends on the type of complaint you have. There are two categories of complaints:

- Quality of care or operational issues; and
- Adverse benefit determinations.

Complaints about quality of care or operational issues are called **grievances**. Complaints about adverse benefit determinations are called **appeals**.

Grievances

Quality of care or operational issues arise if you are dissatisfied with the service received from Aetna or want to complain about a participating provider. To make a complaint about a quality of care or operational issue (called a grievance), call or write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written decision within 30 calendar days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will specify what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

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

The Plan provides for two levels of appeal, plus an option to seek external review of the adverse benefit determination. You must complete 1) two levels of appeal with Aetna; 2) ERO appeal, where available; and 3) any administrative appeals made available to you by the State of Delaware before bringing a lawsuit against the plan. 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 45 days following receipt of the level one notice of adverse benefit determination. The following chart summarizes some information about how appeals are handled for different types of claims.

Type of Claim	Level One Appeal: Response Time From Receipt of Appeal	Level Two Appeal: Response Time From Receipt of Appeal
<p>Urgent care claim: a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment. 	<p>36 hours</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>	<p>36 hours</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>
<p>Pre-service claim: a claim for a benefit that requires approval of the benefit in advance of obtaining medical care.</p>	<p>15 calendar days</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>	<p>15 calendar days</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>
<p>Concurrent care claim extension: a request to extend a previously approved course of treatment.</p>	<p>Treated like an urgent care claim or a pre-service claim, depending on the circumstances.</p>	<p>Treated like an urgent care claim or a pre-service claim, depending on the circumstances.</p>

Post-service claim: a claim for a benefit that is not a pre-service claim.	15 calendar days Review provided by Plan personnel not involved in making the adverse benefit determination.	30 calendar days Review provided by Plan personnel not involved in making the adverse benefit determination.
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You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

Depending on the type of appeal, you and/or an authorized representative may attend the Level Two appeal hearing and question the representative of the Plan and any other witnesses, and present your case. The hearing will be informal. You may bring your physician or other experts to testify. The Plan also has the right to present witnesses.

If the Plan's appeals process upholds the original adverse benefit determination, you may have the right to pursue an external review of your claim. See "External Review" for more information.

External Review

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

You must complete the two levels of appeal described above before you can appeal for external review. 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 level of review within 60 days after you receive the final denial notice.

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

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

An external review is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials and denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment. You may request a review by an external review organization (ERO) if:

- You have received notice of the denial of a claim; and
- Your claim was denied because the care was not medically necessary or was experimental or investigational; and
- You have exhausted the applicable Plan appeal process.

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

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

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

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

Claim Fiduciary

The State of Delaware has complete discretionary authority to review all 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 responsibilities, your employer has discretionary authority to:

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

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

Spousal Coordination Of Benefits

Spouse's Benefits

The benefits for spouses enrolled under this contracted health plan are as follows:

- We pay normal plan benefits if your spouse isn't employed.
- We pay after your spouse's plan pays if your spouse:
 - is eligible for, and,
 - is enrolled in his/her employer's plan
- We pay 20% of allowable covered charges if your spouse:
 - is eligible for, and,
 - is **not** enrolled in his/her employer's plan.

The combined payments can't be more than 100% of covered charges. For more details, see the section, *Coordination of Benefits*.

The above will not apply if your spouse is not enrolled in his/her employer's plan because your spouse:

- doesn't work full time;
- isn't eligible because he/she doesn't work enough hours to be eligible;
- isn't eligible because he/she hasn't completed a waiting period;
- has to pay more than 50% of the plan's cost (including flexible credits); or,
- is not offered health coverage at work.

Coordination of Benefits (COB)

Your contracted health care plan will coordinate payments with any other plan that covers you and your dependents. The combined payments will not exceed 100% of the Allowable Expense. This process is described below.

Your spouse's benefits will be sanctioned, and we will pay 20% for your spouse's benefits if:

- your spouse' employer has a benefit plan;
- your spouse is eligible; and,
- your spouse didn't join the plan.

Terms

These terms are used to explain the rules for Coordination of Benefits (COB):

- *Allowable Expense* is a necessary, reasonable and usual health care expense. The expense must be covered at least in part by a plan that covers you.
- *COB Provision* sets the order in which plans pay when you're covered by two or more plans.
- *Other Plans* is any arrangement you have that covers your health care.
- *Primary Plan* is the plan applied before any other plan. Benefits under this plan are set without considering the other plan's benefits.
- *Secondary Plan* is the plan applied after the other plan. Benefits under this plan may be cut because of the other plan's benefits.

Order of Benefits Determination

The primary and secondary plan payments are set by these rules:

- A plan with no COB rules is primary over a plan with such rules.
- A plan that covers you as an employee is primary over a plan that covers you as a dependent.
- A plan that covers you as an active employee is primary over a plan that covers you as a non-active employee. Non-active means a laid-off or retired employee. This rule applies if you're the employee's dependent.

- For a child covered by plans under both parents, these rules apply:
 - The plan of the parent whose birthday comes first is primary.
 - If both parents have the same birthday, the plan that covered one parent longer is primary.
 - The other plan's COB rules may set the payment order by the parent's gender. In this case, the male parent's plan is primary.
- If the parents are divorced or separated, this order applies:
 - First, the plan of the parent with custody;
 - Then, the plan of the spouse of the parent with custody; and,
 - Last, the plan of the parent not having custody.

This order can change by court decree. A court decree may make one parent responsible for the child's health care costs. If so, that parent's plan is primary.

- If these rules don't decide the primary plan, then the plan covering you longest is the primary.
- There may be two or more secondary plans. If so, these rules repeat until this plan's obligation for benefits is set.

Effect of Benefits

- When this plan is primary, we pay without regard to any secondary plan.
- When this plan is secondary, we account for payments made by other plans. We'll coordinate with the other plans. We'll make sure payments by all plans don't exceed the Allowable Expenses. Our payment will never be more than if we were primary.
- If the other plan is primary and reduces or does not cover benefits because there is coverage under this plan, then we'll calculate the benefit as if:
 - the State's plan is secondary; and,
 - the other plan has paid the normal payment.

How COB Works With Managed Care

The rules below will apply to you, your spouse and your dependent children.

COB When This Plan is Primary

The State's managed care rules must be followed. If you don't, benefits are coordinated by applying the penalties of this plan.

COB When This Plan is Secondary

Your health care plan coverage through the state will never pay more than what we would pay if this plan were primary.

You don't have to follow the State's managed care rules when this plan is secondary. However, you should follow the primary plan's managed care rules.

- If you do, both plans will pay up to the maximum.
- If you don't, we'll apply the other plan's penalties when calculating your benefit payment..

We will coordinate benefits if the primary plan:

- Has a preferred Provider Network; or,
- Is a Point of Service Plan.

You will have to follow the primary plan's In-Network or Out-of-Network managed care guidelines to get the maximum payment.

Exceptions are:

- This plan may cover benefits that the other plan doesn't cover. If this happens, we'll pay benefits as if this plan were primary. You must follow the State's managed care rules to receive maximum payment.
- The other plan may have a day or dollar maximum on a particular benefit. This plan will pay benefits if:
 - you've met the maximum for that benefits; and,
 - this plan covers the particular benefit.

The State's plan will pay until you are again eligible for that benefit under the other plan.

To file a secondary claim, you'll need to send to a completed claim form to Aetna (or a detailed receipt from the provider indicating both the procedure and diagnosis code) and a copy of your Notice of Benefits from the other carrier if applicable. That way we'll be able to see what the primary plan paid and what the managed care penalties were, if any.

Right To Receive and Release Needed Information

We have the right to decide when to apply COB rules. To do this, we may obtain information as needed. We may also release information to any organization or person as needed for payment purposes.

You must give us the information we need to apply COB rules. This includes information about you and your dependents. If you do not cooperate, we may deny payment.

Facility of Payment

If your contracted health care plan through the state is primary, but the other plan paid a claim, we have the right to pay the other plan. Our payment will be the amount we decide is our share under COB rules. Such payment will meet our obligation under this plan.

Right of Recovery

If we paid more than our share under COB rules, we'll recover the excess from:

- you or any person to or for whom such payments were made;
- any insurance plan;
- other organizations.

Subrogation

Subrogation and Right of Recovery Provision

Terms

These terms are used to explain the Subrogation and Right of Recovery provisions:

- *Responsible Party* means any party actually, possible, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.
- *Insurance Coverage* refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.
- *Covered Person* includes anyone on whose behalf the Plan pays or provides any benefits including, but not limited to, the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

Subrogation

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

Reimbursement

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

Constructive Trust

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

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First Priority Claims

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

Applicability To All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

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

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

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

Interpretation

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

Jurisdiction

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

Federal Notices

The Newborns' and Mothers' Health Protection Plan Act

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

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

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

The Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, this Plan covers the follow procedures for a person receiving benefits for an **appropriate** mastectomy:

- Reconstruction of the breast on which a mastectomy has been preformed;
- Surgery and reconstruction of the breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

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

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

HIPAA Certificate of Creditable Coverage

A federal law called HIPAA requires that the State of Delaware Group Health Plan (the "Plan") provide a Certificate of Creditable Coverage (a "Certificate") to each individual who requests one so long as it is requested while the individual is covered under the Plan or within 24 months after the individual's coverage under the Plan ends. A certificate will also be automatically issued on the termination of any individuals covered under the Plan, whether or not a request is made. The request can also be made by someone else on behalf of an individual. For example, an individual who previously was covered under this Plan may authorize a new health plan in which the individual enrolls to request a Certificate from this Plan. An individual is entitled to receive a Certificate upon request even if the Plan has previously issued a Certificate to that individual.

Requests for Certificates should be directed to your organization's Human Resources/Benefits Office. All requests must include:

- The name of the individual for whom the Certificate is requested;
- Where a certificate is requested for a dependent individual, the name of the participant who enrolled in the Plan; and,
- The name of the participant who enrolled the individual in the Plan; and,
- A telephone number to reach the individual for whom the Certificate is requested or the participant who enrolled the individual, in the event of any difficulties or questions.
- The name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- The address to which the Certificate should be mailed; and,
- The requester's signature.

After receiving a request that meets these requirements, your organization's Human Resources/Benefits Office will send a request to the State of Delaware COBRA/HIPAA Administrator to provide the Certificate as soon as administratively feasible.

Rights and Responsibilities

Your Rights and Responsibilities

As a Plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan.
- Obtain primary and preventive care from the PCP you chose from the Plan's network.
- Change your PCP to another available PCP who participates in the Aetna network.
- Obtain covered care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your PCP or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit their website at www.aetna.com. Select DocFind from the drop-down menu under Quick Tools, then under "How do I learn more about:" select the type of plan you're enrolled in.
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered, and any applicable limitations or exclusions.
- Get information about copayments and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

As a Plan participant, you have the responsibility to:

- Choose a PCP from the Plan's network and form an ongoing patient-doctor relationship.
- Help your doctor make decisions about your health care.
- Tell your PCP if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Consult with your PCP for non-emergency referrals to specialist or hospital care.
- See the specialists your PCP refers you to.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Call your PCP before getting care at an emergency facility, unless a delay would be detrimental to your health.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your ID card to providers before getting care from them.
- Pay the copayments and coinsurance required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments and what services are covered and what services are not covered.

Patient Self-Determination Act (Advance Directives)

There may be occasions when you are not able to make decisions about your medical care. An Advance Directive can help you and your family members in such a situation.

What Is an Advance Directive?

An Advance Directive is generally a written statement that you complete in advance of serious illness that outlines how you want medical decisions made.

If you can't make treatment decisions, your physician will ask your closest available relative or friend to help you decide what is best for you. But there are times when everyone doesn't agree about what to do. That's why it is helpful if you specify in advance what you want to happen if you can't speak for yourself. There are several kinds of Advance Directives that you can use to say **what** you want and **whom** you want to speak for you. The two most common forms of an Advance Directive are:

- A Living Will; and
- A Durable Power of Attorney for Health Care.

What Is a Living Will?

A Living Will states the kind of medical care you want, **or do not want**, if you become unable to make your own decisions. It is called a Living Will because it takes effect while you are still living.

The Living Will is a document that is limited to the withholding or withdrawal of life-sustaining procedures and/or treatment in the event of a terminal condition. If you write a living will, give a copy to your PCP.

What Is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a document giving authority to make medical decisions regarding your health care to a person that you choose. The Durable Power of Attorney is planned to take effect when you can no longer make your own medical decisions.

A Durable Power of Attorney can be specific to a particular treatment or medical condition, or it can be very broad. If you write a Durable Power of Attorney for Health Care, give a copy to your PCP.

Who Decides About My Treatment?

Your physicians will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment you don't want — even if the treatment might keep you alive longer.

How Do I Know What I Want?

Your physician must tell you about your medical condition and about what different treatments can do for you. Many treatments have side effects, and your doctor must offer you information about serious problems that medical treatment is likely to cause you. Often, more than one treatment might help you — and people have different ideas about which is best. Your physician can tell you which treatments are available to you, but they can't choose for you. That choice depends on what is important to **you**.

How Does the Person Named in My Advance Directive Know What I Would Want?

Make sure that the person you name knows that you have an Advance Directive and knows where it is located. You might consider the following:

- If you have a Durable Power of Attorney, give a copy of the original to your “agent” or “proxy.” Your agent or proxy is the person you choose to make your medical decisions when you are no longer able.
- Ask your PCP to make your Advance Directive part of your permanent medical record.
- Keep a second copy of your Advance Directive in a safe place where it can be found easily, if it is needed.
- Keep a small card in your purse or wallet that states that you have an Advance Directive and where it is located, and who your agent or proxy is, if you have named one.

Who Can Fill Out the Living Will or Advance Directive Form?

If you are 18 years or older and of sound mind, you can fill out this form. You do not need a lawyer to fill it out.

Whom Can I Name to Make Medical Treatment Decisions When I'm Unable to Do So?

You can choose an adult relative or friend you trust to be your agent or proxy, and to speak for you when you're too sick to make your own decisions.

There are a variety of living will forms available, or you can write your wishes on a piece of paper. If necessary, your doctor and family can use what you write to help make decisions about your treatment.

Do I Have to Execute an Advance Directive?

No. It is entirely up to you.

Will I Be Treated If I Don't Execute an Advance Directive?

Absolutely. We just want you to know that if you become too ill to make decisions, someone else will have to make them for you. With an Advance Directive, you can instruct others about your wishes before becoming unable to do so.

Can I Change My Mind After Writing an Advance Directive?

Yes. You may change your mind or cancel these documents at any time as long as you are competent and can communicate your wishes to your physician, your family and others who may need to know.

What Is the Plan's Policy Regarding Advance Directives?

We share your interest in preventive care and maintaining good health. Eventually, however, every family may face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important in the future and urge you to discuss these topics with your PCP, family, friends, and other trusted, interested people.

You are not required to execute an Advance Directive. **If you choose to complete an Advance Directive, it is your responsibility to provide a copy to your physician and to take a copy with you when you check into a hospital or other health facility so that it can be kept with your medical records.**

How Can I Get More Information About Advance Directives?

Call the Member Services toll-free number on your ID card.

General Information About the Plan

Amendment or Termination of the Plan

The State of Delaware has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified.

The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any nonforfeitable right to continued participation in any benefits plan.

Plan Documents

This Summary Plan Description covers the major features of the HMO Plan administered by Aetna Life Insurance Company, effective July 1, 2007 for the State of Delaware. This Summary Plan Description has been designed to provide a clear and understandable summary of the Plan.

Glossary

Claims Administrator - means the person designated as such by the instrument under which the plan is operated. (If the administrator is not so designated, administrator then means the plan sponsor.) The administrator's responsibilities include but are not limited to:

- Act solely in the interest of the plan participants and beneficiaries, and for the exclusive purposes of providing benefits and defraying reasonable administrative expenses.
- Manage the Plan's assets to minimize the risk of large losses.
- Act in accordance with the documents governing the Plan.

Coinsurance - means the sharing of certain covered expenses by the Plan and the Plan participant. For example, if the Plan covers an expense at 80% (the Plan's coinsurance), your coinsurance share is 20%.

Companion - means a person whose presence as a companion or caregiver is necessary to enable a National Medical Excellence (NME) patient to:

- Receive services from an NME Program provider on an inpatient or outpatient basis; or
- Travel to and from an NME Program provider to receive covered services.

Copayment (copay) - means the fee that must be paid by a Plan participant to a participating provider at the time of service for certain covered expenses and benefits, as described in the "Copayment Schedule."

Cosmetic surgery - means any surgery or procedure that is not medically necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not:

- Restore bodily function;
- Correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or
- Correct or naturally improve a physiological function.

Covered services and supplies (covered expenses) - means the types of medically necessary services and supplies described in "Your Benefits."

Creditable Coverage. - Coverage of the Plan participant under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, including coverage received under a plan established or maintained by a foreign country or political subdivision as well as one established and maintained by the government of the United States, any health benefit plan under section 5(e) of the Peace Corps Act and the State Children's Health Insurance Program (S-CHIP). Creditable Coverage does not include coverage only for accident; Workers' Compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.

Custodial care - means any service or supply, including room and board, which:

- Is furnished mainly to help you meet your routine daily needs;
- Can be furnished by someone who has no professional health care training or skills; or,
- Is at a level such that you have reached the maximum level of physical or mental function and are not likely to make further significant progress.

Detoxification - means the process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.

Durable medical equipment (DME) - means equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Emergency - means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

With respect to emergency services furnished in a hospital emergency department, the Plan does not require prior authorization for such services if you arrive at the emergency medical department with symptoms that reasonably suggest an emergency condition, based on the judgment of a prudent layperson, regardless of whether the hospital is a participating provider. All medically necessary procedures performed during the evaluation (triage and treatment of an emergency medical condition) are covered by the Plan.

Experimental or investigational - means services or supplies that are determined by Aetna to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
- Required FDA approval has not been granted for marketing;
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes;
- The written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes;
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition;
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or,
- It is provided or performed in special settings for research purposes.

Home health services - means those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by Aetna.

Hospice care - means a program of care that is:

- Provided by a hospital, skilled nursing facility, hospice or duly licensed hospice care agency;
- Approved by Aetna; and
- Focused on palliative rather than curative treatment for a Plan participant who has a medical condition and a prognosis of less than 6 months to live.

Hospital - means an institution rendering inpatient and outpatient services, accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation or specialty institution.

Infertility - means:

- For a female who is under age 45 who does not have the ability to conceive after six months without contraception or six cycles of artificial insemination.

Institute of Excellence (IOE)- This is a facility that is contracted with Aetna to furnish particular services and supplies to you and your covered dependents in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Medical services - means those professional services of physicians or other health professionals, including medical, surgical, diagnostic, therapeutic and preventive services authorized by Aetna.

Medically necessary - means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the “Your Benefits” section of this Summary Plan Description. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician’s office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining whether a service or supply is medically necessary, Aetna will consider:

- Information provided on your health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to Aetna’s attention.

In no event will the following services or supplies be considered medically necessary:

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient’s family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician’s or dentist’s office or other less costly setting; or
- Experimental services and supplies, as determined by Aetna.

Member – means an employee, pensioner, and their dependents covered under the Aetna HMO plan.

Mental or nervous condition - means a condition which manifests signs and/or symptoms that are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited to:

- Psychosis;
- Affective disorders;
- Anxiety disorders;
- Personality disorders;
- Obsessive-compulsive disorders;
- Attention disorders with or without hyperactivity; and
- Other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

Outpatient - means:

- A Plan participant who is registered at a practitioner's office or recognized health care facility, but not as an inpatient; or
- Services and supplies provided in such a setting.

Partial hospitalization - means medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be provided in a hospital or non-hospital facility that is licensed as an alcohol, drug abuse or mental illness treatment program by the appropriate regulatory authority.

Participating provider - means a provider that has entered into a contractual agreement with Aetna to provide services to Plan participants.

Physician - means a duly licensed member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where they practice, and who provides medical services which are within the scope of their license or certificate.

Plan – means your Health Maintenance Organization (HMO) benefit program that is sponsored and self-funded by the State of Delaware (State) and administered by Aetna.

Plan administrator – means the third party administrator the State of Delaware has contracted with to administrator its health care plan/s.

Plan benefits - means the medical services, hospital services, and other services and care to which a Plan participant is entitled, as described in this **Summary Plan Description**.

Primary Care Physician (PCP) - means a participating physician who supervises, coordinates, and provides initial care and basic medical services as a general or family care practitioner or, in some cases, as an internist or a pediatrician, to Plan participants; initiates their referral for specialist care; and maintains continuity of patient care.

Provider - means a physician, health professional, hospital, skilled nursing facility, home health agency, or other recognized entity or person licensed to provide hospital or medical services to Plan participants.

Referral - means specific written or electronic direction or instruction from a Plan participant's PCP, in conformance with Aetna's policies and procedures, which directs the Plan participant to a participating provider for medically necessary care.

Service area - means the geographic area, established by Aetna and approved by the appropriate regulatory authority, in which a Plan participant must live or work or otherwise meet the eligibility requirements in order to be eligible as a participant in the Plan.

Skilled nursing facility - means an institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist - means a physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Substance abuse - means any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Summary Plan Description (SPD) – means the written and distributed highlights of a specific type of health care plan for reference by a plan participant.

Terminal illness - means an illness of a Plan participant, which has been diagnosed by a physician and for which they have a prognosis of six (6) months or less to live.

Urgent medical condition - means a medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP.

All services, plans and benefits are subject to and governed by the terms (including exclusions and limitations) of the agreement between Aetna Life Insurance Company and the State of Delaware. The information herein is believed accurate as of the date of publication and is subject to change without notice.