

Emory Health Plan  
Summary Plan Description  
HDHP Health Plan

EMORY



20090213

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The purpose of this Summary Plan Description (“SPD”) is to provide you with a summary of your Benefits in the HDHP Health Plan administered by Aetna. The plan qualifies as a High Deductible Health Plan and once enrolled you may participate in a Health Savings Account (HSA). You may make payroll contributions to your HSA to an account at J.P. Morgan Chase. This is one of the health plan options available in the Emory University Health Care Plan (The “Plan”).

Effective Date: January 1, 2009

## **Eligibility**

### **Employees**

Your eligibility date, if you are then in an eligible class, is the effective date of this Plan. Otherwise, it is the date you start working for Emory or, if later, the date you enter the eligible class. You are in an eligible class for coverage under this Plan if you are:

- A regular full-time or half-time (at least 20 hours per week) employee of Emory.
- A temporary full-time employee on an assignment at Emory University scheduled for at least six consecutive months.
- An Emory retiree who has returned to work at least half-time (at least 20 hours per week).

### **Dependents**

If you elect coverage, your dependents may also be eligible for coverage. Eligible dependents include:

- Your legal spouse under federal and state law.
- Your Same-Sex Domestic Partner (SSDP).\* A Same-Sex Domestic Partner(SSDP) means another adult of the same gender who is engaged with you in a spouse-like relationship characterized by mutual dependency and all of the following requirements apply to both persons:
  - You and your domestic partner are in a committed relationship;
  - You and your domestic partner have reached the age of 18;
  - Neither of you are legally married to another individual;
  - Your relationship is mutually exclusive and you intend that this shall remain the case indefinitely;
  - You are not related by blood to a degree which would prevent you from legally marrying in the state in which you reside, if one was male and the other female;
  - You are jointly responsible for each other’s common welfare and financial obligations;
  - Both you and your domestic partner maintain the same principal place of residence and intend to do so indefinitely.
  - You are responsible to each other for the direction and financial management of your household and intend that this shall remain the case indefinitely; and.
  - You and your Same Sex Domestic Partner must jointly sign the required Statement of Same Sex Domestic Partnership. You intend that all statements in the “Statement of Same Sex Domestic Partnership” will remain true indefinitely.
  - An employee can have only one SSDP enrolled at any time

\*Same Sex Domestic Partner Benefits are not available for employees of Wesley Woods Sr. Living, Inc.

- **Your Child.** Child includes your natural or adopted Child. Also, the following if they reside with you in a parent-child relationship: a Child in the process of being adopted, step-Child, your SSDP's Child or any Child for whom you have legal custody. A Child is eligible if he or she is:
  - Unmarried, under 18 years of age and financially dependent on you.
  - Unmarried, between the ages of 18 and 25, is a full-time student at least five consecutive months during the 12-month period beginning with the child's birthday and financially dependent on you for at least 50% of his or her financial support.
  - Fully disabled (regardless of age) if he or she became disabled prior to age 18, or between the ages of 18 and 25 and was covered by the Plan when the disability occurred. Your child is fully disabled if:
    - He or she is not able to earn his or her own living because of mental retardation or a physical disability which started prior to the date he or she reached the maximum age for dependent children; and
    - He or she depends chiefly on you for support and maintenance.

Proof that your child if fully disabled must be submitted to Emory no later than 31 days after the date your child reaches the maximum age for eligibility.

Coverage for a fully disabled child will cease on the first to occur of:

- Cessation of the disability;
- Failure to provide proof to the Plan Administrator that the disability continues;
- Failure to have any exam required by the Plan Administrator; or
- Termination of dependent coverage as to your child for any reason other than reaching the maximum age for eligibility.

Emory will have the right to require proof of the continuation of the disability. Emory also has the right to have your child examined as often as needed while the disability continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age for dependent coverage.

***No person may be covered both as an employee and dependent of another employee and no person may be covered as a dependent of more than one employee of Emory.***

## **Enrollment Procedure**

Enrolling is easy and available 24 hours a day via Employee Self-Service or e-Vantage through your employer's homepage. You must enroll within 31 days of your eligibility date.

You and Emory share the cost of your health care coverage. Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. Contributions depend

on the coverage you choose. You will receive information on your contributions when you enroll via Employee Self Service.

## **Open Enrollment**

Once you enroll for coverage under this Plan, the coverage will remain in effect unless you make a change during open enrollment or you have a family status change or other special enrollment right which would allow you to change your coverage as described below. Changes made during open enrollment will be effective January 1 of the year following the enrollment.

## **Family Status Changes**

A family status change is an event that may allow you to change your election for this Plan. If one of the situations below applies, you may enroll within 31 days of the event. If you do not enroll within 31 days of the event, you will not be able to enroll until the next open enrollment period. Family status changes include:

- Your marriage, divorce, legal separation or annulment;
- Birth of your child;
- Placement with you of a foster child or child for adoption with you;
- A change in the employment of your spouse or dependent, which affects his or her benefits eligibility, including termination or commencement of employment or a change in worksite;
- An event that would make a dependent child no longer eligible for coverage, such as his or her 18<sup>th</sup> birthday, loss of status as a full-time student, marriage, 25<sup>th</sup> birthday or if you are no longer providing at least 50% of his or her financial support. or
- The death of your dependent

## **Special Enrollment**

If one of the situations below applies, you may enroll within 31 days of the event. If you do not enroll within 31 days of the event, you will be not able to enroll until the next open enrollment period.

## **Loss of Other Health Care Coverage**

You or your dependents may qualify for a special enrollment period if you did not enroll yourself or your dependent when you first became eligible or during any subsequent open enrollments because, at that time you or your dependents were covered under other creditable coverage. You may enroll within 31 days of losing other creditable coverage because of one of the following:

- Termination of the Plan;
- Loss of eligibility under the Plan;
- Death, divorce or legal separation;
- COBRA coverage period ends; or
- You or your dependent reaches the lifetime maximum of another plan for all benefits under that plan.

## **Other Events Which May Entitle You to Midyear Changes**

In addition to the family status changes and special enrollment rights mentioned above you may also have the right to change your coverage within 31 days of the event if one of the following events occurs:

- The employer sponsored cafeteria plan or benefit plan in which your spouse or dependent participates has a different period of coverage than this Plan and your spouse or dependent makes coverage changes under his or her plan based on that coverage period; in this case, you will be allowed to make changes under this Plan consistent with the election of your spouse or dependents effective when their new coverage election takes effect.
- A new medical benefit option is added and you want to switch to the new option; or
- There is a significant increase in the cost of coverage for the option you have selected and you wish to switch to another option for the remainder of the year.
- If you have a new dependent as a result of marriage, birth, adoption or placement for adoption you also have a special enrollment right and you may be able to enroll yourself and your dependents in the Plan.

**If you have a family status change, special enrollment right or another event that entitles you to make mid-year changes, you have 31 days from the date of the event to change your coverage. Your changes must be consistent with your changes in family status or special enrollment right or other event, and must be approved by the Plan Administrator. For example, if you are married and elect family coverage that covers your spouse and your only child, and your child turns 25 and no longer qualifies as a dependent, you may change your coverage to employee and spouse, but not to employee only or no coverage.**

## **Effective Date of Coverage**

### **Employees**

Your coverage will take effect on the later to occur of:

- Your date of hire (if you are eligible right away) or
- The date you became eligible (for example, if you worked fewer than 20 hours per week and transfer to a position in which you work at least 20 hours per week).

If you do not elect coverage within 31 days of your eligibility date, you will not be eligible to enroll in coverage until the next open enrollment period unless you have a family status change or another event that entitles you to make a mid-year change.

### **Dependents**

Coverage for your dependents will take effect on your eligibility date if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions. If you do not enroll dependents within 31 days of any dependent's eligibility date you will not be able to enroll them until the next open enrollment period unless this is a family status change or other event that entitles you to make a midyear change.

### **A Child Who Must Be Covered Due to a Qualified Medical Child Support Order**

You must make written request for such coverage. Coverage for the child will become effective on the date specified by Emory. If you are the non-Custodial Parent, proof of claim for such child may be submitted by the Custodial Parent. Benefits for such claim will be paid to the Custodial Parent.

## **Termination of Coverage**

Your coverage under the Plan will end on the last day of the month in which one of the following events occurs:

- You are no longer employed by Emory;
- You discontinue paying for coverage under COBRA;
- Your eligibility for coverage under COBRA ends;
- You lose your eligibility under the Plan; or
- You stop paying for your coverage.

Your dependent's coverage will end on the last day of the month that:

- Your coverage ends and dependent coverage is not available under COBRA, or your dependent elects not to continue coverage;
- Your dependent discontinues payments for coverage under COBRA;
- You die and your dependent does not elect coverage under COBRA or is not eligible for coverage under COBRA;
- Your dependent loses his or her eligibility under the Plan and does not elect coverage under COBRA or is not eligible for coverage under COBRA;
- You and your SSDP sign a Statement of Termination of Domestic Partnership; or
- Your dependent's eligibility for coverage under COBRA ends.

**Note: If you stop making contributions, your coverage will end on the last day of the month for which a full contribution was credited.**

<b>HDHP Medical Plan Summary Chart</b>	<b>Core</b>	<b>In-Network</b>	<b>Out-Of-Network</b>
<b><i>Deductible</i></b>			
Single	\$1,200	\$1,500	\$2,000
Family	\$2,400	\$3,000	\$4,000
<b><i>Out -Of-Pocket Maximum</i></b>			
Single	\$3,000	\$4,000	\$6,000
Family	\$6,000	\$8,000	\$12,000
Aggregate	N/A	N/A	N/A
<b><i>Physician Fees (Primary Care Office Visits)</i></b> Includes services of an internist, general physician, family practitioner or pediatrician. Also includes dermatologist, allergist and OB/GYN.	20% after Deductible	30% after Deductible	40% after Deductible
<b><i>Physician Fees (Specialist)</i></b>	20% after Deductible	30% after Deductible	40% after Deductible
<b><i>Routine Physical Exams</i></b>			
Routine Adult Physical Exams including immunizations (One exam every 12 months age 18 and over)	\$30 Copay	\$50 Copay	40% after Deductible
Routine GYN Exams (one visit per calendar year - includes Pap smear and related lab fees)	\$30 Copay	\$50 Copay	40% after Deductible
Routine Child Exams including immunizations	\$30 Copay	\$50 Copay	40% after Deductible
Routine Cancer Screening Expenses (includes routine rectal exam/prostate-specific antigen test for covered males age 40 and over)	Plan Pays 100%	Plan Pays 100%	40% after Deductible
Routine Cancer Screening Expenses (colorectal cancer screening for members age 50 and over done in an outpatient setting)	Plan Pays 100%	Plan Pays 100%	40% after Deductible
Routine Mammogram Expenses for covered females age 40 and over	Plan Pays 100%	Plan Pays 100%	40% after Deductible
<b><i>For Use of Urgent Care Provider - Urgent Care</i></b>	20% after Deductible	30% after Deductible	40% after Deductible
<b><i>Emergency Care Per Visit Copay (waived if the person becomes confined in a Hospital)</i></b>	\$150 Copay	\$150 Copay	\$150 Copay
<b><i>Ambulance Expenses</i></b>	20% after Deductible	30% after Deductible	40% after Deductible
<b><i>For Outpatient Hospital Expenses (including surgery)</i></b>	20% after Deductible	30% after Deductible	40% after Deductible
<b><i>Physician Fees for Outpatient Surgery</i></b>	20% after Deductible	30% after Deductible	40% after Deductible
<b><i>Hospital Expenses - Inpatient Coverage</i></b>	20% after Deductible	30% after Deductible	40% after Deductible
Pre-Admission Testing Office Visit	20% after Deductible	30% after Deductible	40% after Deductible
<b><i>Physician Fees for Routine Eye Exam Expenses (1 exam per 12 months) and Hearing (1 exam per 24 months)Non-surgical Office</i></b>	\$30 Copay	\$50 Copay	40% after Deductible

<b>HDHP Medical Plan Summary Chart Continued</b>	<b>Core</b>	<b>In-Network</b>	<b>Out-Of- Network</b>
<b><i>Other Covered Medical Expenses</i></b>			
Convalescent / Skilled Nursing Facility Expenses (120 day maximum, prior hospital confinement not required)	20% after Deductible	30% after Deductible	40% after Deductible
Home Health Care Expenses	20% after Deductible	30% after Deductible	40% after Deductible
Hospice Care Expenses (Inpatient or Outpatient, no limit or dollar maximum)	Plan pays 100%		40% after Deductible
Short-Term Rehabilitation / Outpatient Therapy (Speech, Physical or Occupational) 90 day maximum per year combined	20% after Deductible	30% after Deductible	40% after Deductible
Chiropractic Care / Spinal Manipulation (Limited to 20 visits per calendar year)	20% after Deductible	30% after Deductible	40% after Deductible
Durable Medical and Surgical Equipment	20% after Deductible	20% after Deductible	45% after Deductible
Allergy Testing	20% after Deductible	30% after Deductible	40% after Deductible
Allergy Serum and Injections - If a physician visit is not included then no co-pay applies	20% after Deductible	30% after Deductible	40% after Deductible
<b><i>Family Planning</i></b>			
Maternity - Initial Visit and Post Natal Care Inpatient Care	20% after Deductible	30% after Deductible	40% after Deductible
Vasectomy, Tubal Ligation and Voluntary Abortion	20% after Deductible	30% after Deductible	40% after Deductible
Infertility Treatment Expenses (diagnosis and treatment of the underlying medical condition)	20% after Deductible	30% after Deductible	40% after Deductible
Infertility Expenses includes ovulation inductions and insemination (up to 6 cycles in a lifetime)	20% after Deductible	30% after Deductible	40% after Deductible
For Advanced Reproductive Technology Expenses (ZIFT and GIFT)	No Coverage	No Coverage	No Coverage
<b><i>Diagnostic Laboratory and X-Ray Expenses</i></b>			
Outpatients or Independent Lab	20% after Deductible	30% after Deductible	40% after Deductible
Physician office or Stand along facility	20% after Deductible	30% after Deductible	40% after Deductible
<b><i>Diagnostic X-Ray For Complex Imaging Services (MRI, CAT scan and PET scan)</i></b>	20% after Deductible	30% after Deductible	40% after Deductible
<b><i>Behavioral Health Benefits - Inpatient and Outpatient Treatment</i></b>			
Treatment of Drug and Alcohol Abuse	20% after Deductible	30% after Deductible	40% after Deductible

## Prescription Drug Expense Coverage

This Plan uses a drug formulary, which is a list of medications that are covered under this Plan. The drug formulary is reviewed to ensure it includes medications for most medical conditions and includes many:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications, of which at least one ingredient is a legend drug
- Insulin
- Needles, syringes and over the counter diabetic supplies

All covered medications are categorized into five tiers, and each tier has different Copays. Your cost depends on which tier your medication is in.

- **Tier Zero** – Select Generics used to treat diabetes, congestive heart failure, high blood pressure and high cholesterol
- **Tier One** – Generics and select Brand Name Medications used to treat diabetes, congestive health failure, high blood pressure and high cholesterol.
- **Tier Two** – Other Brand Name Medications used to team diabetes, congestive heart failure, high blood pressure and high cholesterol and certain Brand Name Medications used to treat other health conditions.
- **Tier Three** – Brand Name Medications
- **Tier Four** – Personal choice Brand Name Medications

Copayments	Retail Up to 30 Days	Mail Up to 90 Days
Tier Zero	-0-	-0-
Tier One	\$12	\$30
Tier Two	\$25	\$62
Tier Three	\$50	\$125
Tier Four	\$70	\$175

### Limitations

No Benefits are paid under this section for:

- Any drug entirely consumed at the time and place it is prescribed;
- The administration or injection of any drug;
- Any drug provided by or while the person is a patient in any health care facility or for any drug provided on an outpatient basis in any health care facility to the extent Benefits are paid for it under any other part of this Plan or under any other medical or Prescription Drug expense benefit Plan carried or sponsored by Emory;

- Any drugs which do not, by federal or state law, require a prescription order (i.e. an over-the-counter (OTC) drug), even if a prescription is written;
- Any Prescription Drug for which there is an over-the-counter (OTC) product which has the same active ingredient and strength;
- Immunization agents;
- Biological sera and blood products;
- Nutritional supplements;
- Any smoking cessation aids or drugs; or
- Appetite suppressants.

## **Your Health Benefits**

This Plan will pay Benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no Benefits are payable for expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by the Claims Administrator. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Although a specific service may be listed as a covered expense, it may not be covered unless it is Medically Necessary for the prevention, diagnosis or treatment of an illness or condition. There are exclusions, Deductibles, Copayment features and stated maximum benefit amounts.

All maximums included in this Plan are combined maximums between Core, In-Network and Out-of-Network, where applicable, unless specifically stated otherwise.

## **Provider Networks**

To obtain a listing of network providers:

- Aetna Member services at 800-847-9026
- Log-on at Aetna Navigator at [www.aetna.com/docfind/custom/emory](http://www.aetna.com/docfind/custom/emory)

For medical Benefits, Core Network Providers give you the maximum benefit available under the Plan, with lower Copays. Out-of-Network providers are not contracted with the network therefore; your out of pocket cost will be the highest.

## **Covered Medical Expenses**

### **Certification for Certain Procedures and Treatments**

Certification by Aetna of the necessity of certain procedures and treatments is required before the procedure is performed or before the treatment starts unless such procedure or treatment has been ordered and prescribed by your Primary Care Physician; or a Core or In-Network Provider.

When any of the procedures or treatments shown below are to be performed on an inpatient or outpatient basis, covered medical expenses incurred in connection with the performance of the procedure or treatment will be payable as follows:

- If the procedure or treatment is not necessary: No Benefits will be payable whether or not certification has been requested.
- If certification has been requested and the procedure or treatment is necessary: Benefits will be payable at the Copay or applicable Deductible and Coinsurance based on the place of service.
- If certification has not been requested and the procedure or treatment is necessary: Expenses incurred in connection with its performance, up to the Excluded Amount, will not be considered to be Covered Medical Expenses.

Benefits for covered medical expenses in excess of the Excluded Amount will be payable at the Copay or applicable Deductible and Coinsurance based on the place of service.

### **List of Procedures and Treatments**

The following procedures or treatments require certification, unless prescribed by a Core or In-Network provider, before the procedure or treatment is performed. Even though the procedures or treatments are most often done on an outpatient basis, certification is required whether the procedure or treatment will be performed on an inpatient basis or on an outpatient basis.

Allergy Immunotherapy  
Bunionectomy  
Carpal Tunnel Surgery  
Colonoscopy  
Computerized Axial Tomography  
(CAT Scan)-Spine  
Coronary Angiography  
Dilation/Curettage  
Hemorrhoidectomy  
Knee Arthroscopy  
Laparoscopy (pelvic)  
Magnetic Resonance Imaging (MRI)-Knee  
Magnetic Resonance Imaging (MRI)-Spine  
Septorhinoplasty  
Tympanostomy Tube  
Upper GI Endoscopy  
Cataract Removal  
Septoplasty  
Strabismus Repair  
Hammertoe Repair

You or the provider performing the procedure or treatment must call the number shown on your ID card to request certification.

If the procedure or treatment is performed due to an emergency condition, the call must be made before the procedure or treatment is performed or not later than 48 hours after the procedure or treatment is performed unless the call cannot be made within that time. In that case, the call must be made as soon as it is reasonably possible. In the event the procedure or treatment is performed on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

If the procedure or treatment is performed for any condition other than an emergency condition, the call must be made at least 14 days before the date the procedure is to be performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

Written notice of the certification decision will be sent promptly to you and the provider performing the procedure or treatment. This decision will be valid for 60 days from the date you receive the notice. If the procedure or treatment is to be performed after this 60 day period, certification must again be requested, as described above.

### **Inpatient Hospital Expenses**

Inpatient Hospital expenses include charges made by a Hospital for giving board and room and other Hospital services and supplies to a person who is confined as a full-time inpatient.

For Core or In-Network care, if a private room is used, the daily Board and Room Charge will be covered if the person's Core or In-Network provider requests the private room, and the request is approved by the Claims Administrator. If these procedures are not met, any part of the daily Board and Room Charge that is more than the Semiprivate room rate is not covered.

For Out-of-Network Care, any charge for daily board and room in a private room over the Semiprivate room rate is not covered.

### **Certification for Hospital Admissions**

This certification section applies to Hospital admissions other than those for the treatment of alcoholism, drug abuse, or Mental Disorders.

If a person becomes (a) confined in a Hospital as a full-time inpatient and it has not been certified that such confinement (or any day of such confinement) is necessary and (b) the confinement has not been ordered and prescribed by a Core or In-Network Care Provider, the covered medical expenses incurred on any day not certified during the confinement will be paid as follows:

As to Hospital expenses incurred during the confinement if certification has been requested and denied, no Benefits will be paid for Hospital expenses incurred for room and board. If certification has not been received, but the stay is determined to be necessary, the first \$750 will be an Excluded Amount therefore not a covered expense. Charges after the first \$750 will be paid as any other Hospital Expense.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan.

Certification of days of confinement can be obtained as follows: If the admission is a non-urgent admission, you must get the number of days certified by calling the number shown on your ID card for certification. This phone call must be made at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an emergency admission or an urgent admission, you, the person's physician, or the Hospital must get the number of days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient that requires an urgent admission; or
- not later than 48 hours following the start of a confinement as a full-time inpatient that requires an emergency admission; unless it is not possible for the physician to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If, in the opinion of the person's physician, it is necessary for the person to be confined for a longer time than already certified, you, the person's physician or the Hospital may request that more days be certified by calling the number shown on your ID card. This call must be made no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the Hospital by Aetna. A copy will be sent to you and to the physician.

### **Outpatient Hospital Expenses**

Outpatient Hospital expenses include charges made by a Hospital for Hospital services and supplies that are given to a person who is not confined as a full-time inpatient.

### **Outpatient Surgical Expenses**

Outpatient surgical expenses that are covered under the Plan include charges made in its own behalf by a Surgery Center, the outpatient department of a Hospital or an office-based surgical facility of a Physician or a Dentist.

### **Convalescent Facility Expenses**

Convalescent Facility expenses include charges made by a Convalescent Facility for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily board and room in a private room over the Semiprivate rate;
- Use of special treatment rooms;
- X-ray and lab work;
- Physical, occupational or speech therapy;
- Oxygen and other gas therapy;
- Other medical services usually given by a Convalescent Facility. This does not include private or special nursing or physician's services; or
- Medical Supplies;

Benefits will be paid for no longer than the Convalescent Facility days maximum during any one calendar year.

### **Limitations to Convalescent Facility Expenses**

This section does not cover charges made for treatment of:

- Drug addiction;
- Chronic brain syndrome;
- Alcoholism;
- Senility;
- Mental retardation; or
- Any other Mental Disorder

### **Home Health Care Expenses**

Home health care expenses are covered if:

- the charge is made by a Home Health Care Agency; and
- the care is given under a Home Health Care Plan; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a Hospital or Convalescent Facility:
  - medical supplies;
  - drugs and medicines prescribed by a physician; and
  - lab services provided by or for a home health care agency.

There is a maximum number of visits covered in a plan year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

### **Limitations to Home Health Care Expenses**

This section does not cover charges made for:

- Services or supplies that are not a part of the Home Health Care Plan;
- Services of a person who usually lives with you or who is a member of your or your spouse's or SSDP's family;
- Services of a social worker; or
- Transportation

### **Preventive Care**

Preventive care can help you identify potential health risks before they become real health problems. Preventive care Benefits such as routine physicals, examinations, well child visits and immunizations are covered services under the Plan. The cost for the service is based on where the service is received.

Additionally, if you use a Core or In-Network provider certain procedures are paid 100% by the Plan:

- For females over age 40, one preventive mammogram each year;

- For males over age 40, routine digital rectal exam / prostate-specific antigen test (PSA) - one exam or test each year; and
- For anyone age 50 and over, a preventive colonoscopy.

### **Routine Physical Exam Expenses**

The charges for a routine physical exam given to a Covered Person may be included as covered medical expenses. A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease.

For a dependent child:

To qualify as a covered physical exam, the physician's exam must include at least:

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

For all exams given to your child under age 7, covered medical expenses will not include charges for:

- More than 7 exams in the first year of the child's life.
- More than 2 exams in the second year of the child's life; and thereafter
- More than one exam per 12 months through their 17<sup>th</sup> year.

### **Routine Eye Exam Expenses**

Covered Medical Expenses include charges for a complete eye exam, including refraction, which is furnished by a legally qualified ophthalmologist or optometrist.

Covered Medical Expenses will not include charges for more than one eye exam in 12 months in a row.

### **Routine Hearing Exam Expenses**

Covered Medical Expenses include charges for an audiometric exam. The services must be performed by a Primary Care Physician.

Covered Medical Expenses will not include charges for more than one hearing exam in 24 months in a row.

### **Hospice Care Expenses**

Charges made for the following when given as a part of a Hospice Care Program are included as Covered Medical Expenses.

Facility Expenses - the charges made in its own behalf by a Hospice Facility Hospital or a Convalescent Facility which are for:

Inpatient Care - Board and room and other services and supplies furnished to a person while a full-time inpatient for pain control and other acute and chronic symptom management.

Not included is any charge for daily board and room in a private room over the semi-private room rate.

## Outpatient Care

- Services and supplies furnished to a person while not confined as a full-time inpatient.
- Other expenses for outpatient care
- Charges made by a Hospice Care Agency for:
  - Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours in any one day;
  - Medical social services under the direction of a physician. These services include assessment of the person's social, emotional, and medical needs; the home and family situation; identification of the community resources which are available to the person and assisting the person to obtain those resources needed to meet the person's assessed needs;
  - Psychological and dietary counseling;
  - Consultation or case management services by a physician;
  - Physical and occupational therapy;
  - Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person;
  - Medical supplies; and
  - Drugs and medicines prescribed by a physician.

Charges made by the providers below for outpatient care, but only if the provider is not an employee of a Hospice Care Agency and such agency retains responsibility for the care of the person.

- A physician for consultant or case management services.
- A physical or occupational therapist.
- A Home Health Care Agency for:
  - physical and occupational therapy;
  - part-time or intermittent home health aide services for up to 8 hours in any one day (these consist mainly of caring for the person)
  - medical supplies;
  - drugs and medicines prescribed by a physician; and
  - psychological and dietary counseling.

Not included are charges made for:

- Bereavement counseling;
- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling - this includes estate planning and the drafting of a will;
- Homemaker or caretaker services - these are services that are not solely related to care of the Covered Person. Including but not limited to, sitter or companion services for either the person who is ill or other members of the family, transportation, house cleaning, or maintenance of the house; and
- Respite care: this is care furnished during a period of time when the Covered Person's family or usual caretaker cannot, or will not, attend to the Covered Person's needs.

## **Infertility Services Expenses**

Even though not incurred for treatment of a disease or injury, covered medical expenses will include expenses incurred by a covered female for infertility if all of the following tests are met:

- There exists a condition that:
  - is a demonstrated cause of infertility; and
  - has been recognized by a gynecologist or infertility Specialist who is a Core or In-Network Provider; and
  - is not caused by voluntary sterilization or a hysterectomy;

or

- For a female who is:
  - under age 35, and who has not been able to conceive after one year or more without contraception; or
  - age 35 or older, and who has not been able to conceive after six months without contraception.

and

- The procedures are performed while not confined in a Hospital or any other facility as an inpatient.
- Follicle-Stimulating Hormone (FSH) levels are less than or equal to 19 miU on day 3 of the menstrual cycle.

The following infertility services expenses will be covered medical expenses:

- Ovulation induction with ovulatory stimulant drugs, subject to a maximum of six courses of treatment in a covered person's lifetime.
- Artificial insemination, subject to a maximum of six courses of treatment in a covered person's lifetime.

These expenses will be covered on the same basis as for disease.

A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.

Not covered are charges for:

- Purchase of donor sperm or storage of sperm;
- Care of donor egg retrievals or transfers;
- Cryopreservation or storage of cryopreserved embryos;
- Gestational carrier programs;
- Home ovulation prediction kits;
- In vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection;
- Frozen embryo transfers, including thawing; and

### **Pregnancy Coverage**

Benefits are payable for pregnancy-related expenses of a Covered Person on the same basis as for a disease.

#### **In the event of an inpatient confinement:**

- Such Benefits will be payable for inpatient care of the covered person and any newborn child for (a) a minimum of 48 hours following a vaginal delivery; and (b) a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, Benefits will be payable for two post-delivery home visits by a health care provider.

- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling Aetna at the number shown on your ID card for certification.

**Prior Plans:** Any pregnancy Benefits payable by previous group medical coverage will be subtracted from medical Benefits payable for the same expenses under this Plan.

### **Family Planning**

The charges made by a Physician or a Hospital for the following services even though they are not incurred in connection with the diagnosis or treatment of a disease or injury, are Covered Medical Expenses.

Benefits will be payable for a:

- Vasectomy for voluntary sterilization; and
- Tubal ligation for voluntary sterilization.

Not covered are charges for the reversal of a sterilization procedure.

### **Short-Term Rehabilitation**

Short-term rehabilitation is therapy that is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to an injury, a disease, or Congenital Anomaly.

Short-term rehabilitation services include physical therapy, occupational therapy and speech therapy, furnished to a person who is not confined as an inpatient in a Hospital or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Any services which are covered expenses in whole or in part under any other group Plan sponsored by Emory;
- Services received while the person is confined in a Hospital or other facility for medical care;
- Services not performed by a physician or under his or her direct supervision;
- Services rendered by a physical, occupational, or speech therapist who resides in the Covered Person's home or who is a part of the family of either the Covered Person or the Covered Person's spouse;
- Services rendered for the treatment of delays in speech development, unless resulting from disease or injury;
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired. This includes lessons in how to function without that ability; and
- Treatment for which a benefit is or would be provided under the Spinal Manipulation Expenses section, whether or not Benefits for the maximum number of visits under that section have been paid;

Also not covered are any services unless they are provided in accordance with a specific treatment plan that details the treatment to be rendered and the frequency and duration of the treatment and provides for ongoing reviews and is renewed only if therapy is still necessary.

### **Spinal Manipulation Expenses**

Covered medical expenses include charges for treatment of spinal subluxation or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the spinal manipulation maximum visits will be payable in any one calendar year.

The maximum does not apply to expenses incurred:

- While the person is a full-time inpatient in a Hospital;
- For treatment of scoliosis;
- For fracture care; or
- For surgery - this includes pre and post surgical care given or ordered by the operating Physician.

### **Durable Medical and Surgical Equipment Expenses**

Covered medical expenses include the following:

- The rental of Durable Medical and Surgical Equipment;
- The initial purchase of Durable Medical and Surgical Equipment and accessories needed to operate it only if the Claims Administrator is shown that long term use is planned and the equipment cannot be rented or it is likely to cost less to buy it than to rent it;
- The repair or replacement of purchased Durable Medical and Surgical Equipment and accessories. Replacement will be covered only if the Claims Administrator is shown that it is needed due to a change in the covered person's physical condition or it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment; and
- Charges for oxygen

The following are not covered medical expenses:

- More than one item of equipment for the same or similar purpose;
- Equipment that is normally of use to persons who do not have a disease or injury;
- Equipment for use in altering air quality or temperature; and
- Equipment for exercise or training.

### **Mouth, Jaws and Teeth**

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those expenses for services rendered and supplies needed for the following treatment of or related to conditions of the teeth, mouth, jaws, jaw joints, or supporting tissues (this includes bones, muscles, and nerves).

For these expenses, "Physician" includes a Dentist.

- Covered Medical Expenses include surgery needed to:
  - Treat a fracture, dislocation, or wound;

- Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues;
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth; and
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.
- Dental work, surgery and Orthodontic Treatment needed to remove, repair, replace, restore or reposition natural teeth damaged, lost, or removed; or other body tissues of the mouth fractured or cut due to injury. Any such teeth must have been free from decay or in good repair and in both cases firmly attached to the jaw bone at the time of the injury. The treatment must be done in the plan year of the accident or the next one if crowns (caps); dentures (false teeth); bridgework; or in-mouth appliances; are installed due to such injury. Covered Medical Expenses include only charges for the first denture or fixed bridgework to replace lost teeth; the first crown needed to repair each damaged tooth; and an in-mouth appliance used in the first course of Orthodontic Treatment after the injury.
- Except for injury, the following are not covered medical expenses:
    - In-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
    - Root canal therapy;
    - Routine tooth removal (not needing cutting of bone).
- The following are not Covered Medical Expenses:
    - Provided to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
    - Provided for repair, replace, or restore fillings, crowns, dentures or bridgework;
    - Non-surgical periodontal treatment;
    - Dental cleaning, in-mouth scaling, planning or scraping;
    - Myofunctional therapy (muscle training therapy);
    - Training to correct or control harmful habits; or
    - Treatment of temporomandibular joint syndrome(TMJ).

### **Complex Imaging Services**

Covered Medical Expenses include charges for complex imaging services received by a Covered Person on an outpatient basis when performed in a Physician's office, a Hospital outpatient department, emergency room; or a licensed radiological facility.

Complex Imaging Services include:

- Computed Axial Tomography(CAT) Scans;
- Magnetic Resonance Imaging (MRIs);

- Positron Emission Tomography (PET Scans); and
- any other outpatient diagnostic imaging service costing over \$ 500.

### **Other Medical Expenses**

These include:

- Charges made by a Physician.
- Charges made by a Physician for Acupuncture.
- Charges for the following:
  - Drugs and medicines which by law need a Physician's prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.
  - Diagnostic lab work and X-rays.
  - X-rays, radium, and radioactive isotope therapy.
  - Anesthetics and oxygen.
  - Professional ambulance service to transport a Covered Person from the place where he or she is injured or stricken by disease to the first Hospital where treatment is given.
  - Artificial limbs and eyes.

Not included are charges for:

- eyeglasses;
- vision aids;
- hearing aids;
- communication aids; and
- orthopedic shoes unless necessary to prevent complications of diabetes.

### **National Medical Excellence Program ® (NME)**

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an NME Patient's local geographic area. When care is directed to a medical facility more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

#### **Travel Expenses**

These are expenses incurred by an NME Patient for transportation between his or her home and the medical facility to receive services in connection with a procedure or treatment. Also included are expenses incurred by a Companion for transportation when traveling to and from an NME Patient's home and the medical facility to receive such services.

All travel expenses must be approved in advance by the Claims Administrator.

#### **Lodging Expenses**

These are expenses incurred by an NME Patient for lodging away from home while traveling between his or her home and the medical facility to receive services in connection with a procedure or treatment.

Also included as covered medical expenses are expenses incurred by a Companion for lodging away from home:

- while traveling with an NME Patient between the NME Patient's home and the medical facility to receive services in connection with any listed procedure or treatment; or

- when the Companion's presence is required to enable an NME Patient to receive such services from the medical facility on an inpatient or outpatient basis.

All lodging expenses must be approved in advance by the Claims Administrator.

Benefits paid for Travel Expenses and Lodging Expenses do not count against any covered person's Maximum Benefit.

### **Limitations**

Travel expenses and Lodging Expenses do not include, and no Benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one Companion who is traveling with the NME Patient.

### **Behavioral Health Coverage**

When you are ready to access your Benefits, please call Aetna's Behavioral Health toll-free number 800-424-4047, which is available 24 hours-a-day, seven days-a-week. A Behavioral Health Customer Service Representative will provide you with assistance in locating a network provider. If you need additional assistance, a clinical Care Manager will answer your call and begin the assessment process. During this call, the Care Manager assesses your issue, to ensure that you receive the level of care that you need to address your symptom(s) and its level of acuity. To assess your symptoms, Aetna uses a set of industry-approved and clinically based guidelines. After Aetna assesses your personal situation, you will be referred to a Network Provider who is experienced in addressing your specific situation. If you fail to utilize Aetna network providers, you will receive lower, Out-of-Network Benefits for your care.

The care you receive through your Behavioral Health Benefit is confidential. Aetna shall not disclose confidential information to anyone without your consent, except where required by federal and state laws.

If you are unsatisfied with your current network provider, call Aetna and ask for a referral to another Network Provider. You will receive one Network Provider referral at a time, but you can change more than once.

### **Emergency Care**

If you are facing a crisis and must go to an emergency room, you do not need a referral from Aetna. Aetna needs to be contacted only if you are admitted to the hospital or facility.

Once Emergency Care has ended, call Aetna for assistance with locating a provider or other community resources to assist in your follow up care.

Behavioral Health Care includes services and supplies which are:

- Covered services, for mental health and substance abuse treatment;
- Given while the Covered Person is covered under this Plan;
- Given by one of the following:
  - Psychologist

- Licensed Behavioral Health Counselor
- Provider
- Hospital
- Treatment Center
- Social Worker

Behavioral Health Services includes but is not limited to the following:

- Assessment
- Diagnosis
- Treatment Planning
- Medication Management
- Individual, family and group psychotherapy
- Psychological testing

**Behavioral health services requiring precertification/ authorization**

This applies only to services covered under the member’s benefits plan.

- Inpatient admissions
- Residential Treatment Center (RTC) admissions
- Partial Hospitalization Programs (PHPs)
- Intensive Outpatient Programs (IOPs)
- Psychological testing
- Neuropsychological testing
- Outpatient Electroconvulsive Therapy (ECT)
- Biofeedback
- Amytal interview
- Hypnosis
- Psychiatric home care services
- Outpatient detoxification

Services and supplies will not automatically be considered Covered Health Services solely because there were prescribed by a Provider.

**Benefit Maximums**

Convalescent and Skilled Nursing Facility	120 days per calendar year
Home Health Care Maximum Visits	120 visits per calendar year
Short-Term Rehabilitation Maximum Visits	90 visits per calendar year
Spinal Manipulation	20 visits per calendar year
Artificial Insemination / Ovulation Induction	6 courses of treatment

Private Room Limit	The institution's Semiprivate rate
Lifetime Maximum Benefit	\$2,000,000

## General Exclusions

### General Exclusions Applicable to Your Medical Benefits

Coverage is not provided for the following charges:

- Services and supplies not necessary, as determined by the Claims Administrator, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending physician or Dentist;
- Care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending Physician or Dentist;
- In connection with, services or supplies that are, as determined by the Claims Administrator, experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or if required by the FDA, approval has not been granted for marketing; or a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, 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, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if the Claims Administrator determines that the disease can be expected to cause death within one year, in the absence of effective treatment; and the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Claims Administrator will take into account the results of a review by a panel of independent medical professionals. They will be selected by the Claims Administrator. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute if the Claims Administrator determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease;

- Services, treatment, education testing, or training related to learning disabilities or developmental delays;
- Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury;
- The following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy;

- Treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field;
- Services of a resident physician or intern rendered in that capacity;
- Those that are made only because there is health coverage;
- Treatment of temporomandibular joint syndrome(TMJ);
- Those that a covered person is not legally obliged to pay;
- Custodial Care as determined by the Claims Administrator;
- Services and supplies furnished, paid for, or for which Benefits are provided or required by reason of the past or present service of any person in the armed forces of a government. Furnished, paid for, or for which Benefits are provided or required under any law of a government (this exclusion will not apply to "no fault" auto insurance if it is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to a Plan established by government for its own employees or their dependents or Medicaid);
- Eye surgery mainly to correct refractive errors;
- Education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment;
- Therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis;
- Artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in this Summary Plan Description.
- Routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in this Summary Plan Description;
- Marriage, family, child, career, social adjustment, pastoral, or financial counseling;
- Speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Weight control services including: weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications; food or food supplements; exercise programs; exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity. Under certain criteria Morbid Obesity surgical procedures may be covered if provided by a Core Network or In-Network provider, but only with a Body Mass Index (BMI) exceeding 40; or a BMI greater than 35 with one of the following co-morbidities which is aggravated by obesity: Coronary heart disease or Type 2 diabetes mellitus.
- Plastic surgery, reconstructive surgery, Cosmetic Procedures, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to improve the function of a part of the body that is not a tooth or structure that supports the teeth; and is malformed as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or as a direct result of disease; or surgery performed to treat a disease or injury;
- Services related to an injury must be performed in the calendar year of the accident which causes the injury or in the next calendar year;

- Those to the extent they are not Reasonable Charges, as determined by the Claims Administrator;
- Reversal of a sterilization procedure; and
- Service or supply furnished by a Core Network or In-Network Provider in excess of such provider's Negotiated Charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the Benefits of the group contract are paid.

## **General Exclusions Applicable to Your Mental Health and Substance Abuse Benefits**

The following exclusions apply regardless of whether the services, supplies, or treatment described in this section are recommended or prescribed by your provider and / or the only available treatment options for your condition.

Aetna does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM);
- Services or supplies for Mental Health Disease and Treatment that, in the reasonable judgment of Aetna are any of the following:
  - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
  - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;
  - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or
  - not consistent with Aetna's level of care guidelines or best practice as modified from time to time.

Aetna may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

- Treatment of services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation (317,318,319), Learning, Motor Skills, and Communication Disorders (315), Pervasive Developmental Disorder (299), Conduct Disorder (312), Dementia (290, 294), Sexual, Paraphilia, and Gender Identity Disorders (302), and Personality Disorders (301), as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by UBH;
- Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a Covered Service if the

service, treatment, or device is considered to be unproven, investigational, or experimental;

- Custodial Care except for the acute stabilization and return back to your baseline level of individual functioning. Care is determined to be Custodial Care when:
  - it provides a protected, controlled environment for the primary purpose of protective detention and / or providing services necessary to assure competent functioning in activities of daily living; or
  - it is not expected that the care provided or psychiatric treatment alone will reduce this disorder, injury or impairment to the extent necessary to function outside a structured environment. This applies when there is little expectation of improvement in spite of any and all treatment attempts.
  - Repeated and volitional non-compliance with treatment recommendations result in a situation in which there can be no reasonable expectation of a successful outcome.
- Neuropsychological testing when used for the diagnosis of attention deficit disorder;
- Examinations or treatment, unless it otherwise qualifies as Behavioral Health Care, when:
  - required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
  - ordered by a court except as required by law;
  - conducted for purposes of medical research; or
  - required to obtain or maintain a license of any type.
- Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of National Institutes of Health;
- Nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan;
- Weight reduction or control programs (unless there is a diagnosis of Morbid Obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies;
- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the providers' licensure;
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners;
- Light boxes and other equipment, whether associated with a behavioral or non-behavioral condition;
- Private duty nursing services while confined in a facility;
- Gender altering surgical procedures including but not limited to sex transformation operations;
- Smoking cessation related services and supplies;
- Travel or transportation expenses unless Aetna has requested and arranged for you to be transferred by ambulance from one facility to another;
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself;
- Services performed by a provider with the same legal residence as you;
- Behavioral Health Care for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;

- Charges in excess of any specified Plan limitations;
- Any charges for missed appointments;
- Any charges for record processing except as required by law;
- Services provided under another Plan. Service or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes but is not limited to coverage required by workers' compensation, no-fault auto, or similar legislation. If coverage under workers' compensation or a similar law is optional for you because you could elect it or could have it elected for you, Benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected;
- Behavioral Health Care received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when you are legally entitled to other coverage; and
- Treatment or services received prior to you being eligible for coverage under the Plan or after the date your coverage under the Plan ends.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These Excluded Amounts will not be used when figuring Benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some Benefits. If so, they will not be paid.

## **Effect of Benefits under Other Plans**

### **Coordination of Benefits - Other Plans Not Including Medicare**

This Coordination of Benefits (COB) provision applies to this Plan when an employee or the employee's covered dependent has medical and/or dental coverage under more than one Plan. "Plan" is defined herein.

### **Right to Receive and Release Needed Information**

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

### **Right of Recovery**

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

The order of benefit determination rules as discussed below determines which Plan will pay as the primary Plan. The primary Plan pays first without regard to the possibility that another Plan may cover some expenses. A secondary Plan pays after the primary Plan and may reduce the

Benefits it pays so that payments from all group Plans do not exceed 100% of the total Allowable Expense. When two or more Plans pay Benefits, the rules for determining the order of payment are as follows:

- The primary Plan pays or provides its Benefits as if the secondary Plan or Plans did not exist.
- A Plan that does not contain a coordination of Benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide Out-of-Network benefits.
- A Plan may consider the Benefits paid or provided by another Plan in determining its Benefits only when it is secondary to that other Plan.
- The first of the following rules that describes which Plan pays its Benefits before another Plan is the rule to use:
  - Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary, and as a result of federal law, Medicare is a secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee) then the order of Benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.
- Child Covered Under More Than One Plan. The order of Benefits when a child is covered by more than one Plan is:
  - The primary Plan is the Plan of the parent whose birthday is earlier in the year if:
    - The parents are married;
    - The parents are not separated (whether or not they ever have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the Plan that covered either of the parents longer is primary.
  - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or Plan years commencing after the Plan is given notice of the court decree.
  - If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of Benefits is:
    - The Plan of the Custodial Parent;
    - The Plan of the spouse of the Custodial Parent;
    - The Plan of the non-Custodial Parent; and then
    - The Plan of the spouse of the non-Custodial Parent.

- **Active or Inactive Employee.** The Plan that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule.
- **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Benefits, this rule is ignored.
- **Longer or Shorter Length of Coverage.** The Plan that covered the person as an employee, member or subscriber longer is primary.

If the preceding rules do not determine the primary Plan, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than it would have paid had it been primary.

## **Effect of Medicare**

Medical Coverage under this Plan will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she is covered under it or is not covered under it because of having refused it; having dropped it; or having failed to make proper request for it.

These are the charges this Plan will pay:

- The amount this Plan will pay will be figured so that this amount, plus the benefits under Medicare, will equal 100% of "Plan Expenses". "Plan Expenses" means any necessary and reasonable health expenses, part or all of which is covered under this Plan.
- Charges used to satisfy a person's Part B Deductible under Medicare will be applied under this Plan in the order received by the Claims Administrator. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's Benefits have been figured under the above rules.
- Any benefits under Medicare will not be deemed to be an Allowable Expense.

If it is necessary in order to administer this provision, the Claims Administrator has the right to release or obtain data and make or recover any payments.

Coverage will not be changed for any Covered Person at any time when Emory's compliance with federal law requires this Plan's Benefits for a person to be determined before Benefits are available under Medicare.

## **Additional Provisions**

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the plan document on file with Emory. If you have any questions about the terms of this Plan or about the proper payment of Benefits, you may obtain more information from Emory.

Emory hopes to continue this Plan indefinitely, but as with all group Plans; this Plan may be changed or discontinued as to all or any class of employees.

## **Assignments**

Coverage may be assigned only with the written consent of the Claims Administrator.

## **Reimbursement Provision**

If a Covered Person suffers a loss or an injury caused by the act or omission of a third party, the Benefits in this Plan for such loss or injury will be paid only if the Covered Person, or his or her legally authorized representative, agrees in writing to:

- Pay the Claims Administrator up to the amount of the Benefits received under this Plan subject to applicable law if damages are collected. Damages may be collected by action at law; settlement; or otherwise;
- Provide the Claims Administrator a lien in the amount of the benefit paid. This lien may be filed with the third party; his or her agent; or a court which has jurisdiction in the matter. The payment and the lien referred to above shall be made or provided to the Claims Administrator in its capacity as the provider of administrative services to this Plan.

## **Subrogation and Right of Recovery Provision**

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injuries, illness, or condition, including the liability insurer of such party, or any insurance carrier providing medical expense 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.

Immediately upon paying or providing any Benefit under this Plan, the Plan shall be subrogated to 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 injuries or illness, to the full extent of Benefits provided or to be provided by the Plan.

In addition, if a Covered Person receives any payment from any Responsible Party 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 all Responsible Parties. By accepting Benefits (whether the payment of such Benefits is made to the

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

Further, the Plan will automatically have a lien, to the extent of Benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a Covered Person receives from any Responsible Party as a result of the Covered Person's injuries, illness, or condition.

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 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 the attorney hired by the Covered Person to pursue the Covered Person's damage claim.

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 or non-economic damages only.

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 attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the Covered Person. The Covered Person shall provide all information requested by the Plan, the Claim Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. 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.

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

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

## **Recovery of Overpayment**

If a benefit payment is made by the Claims Administrator, to or on behalf of any Covered Person, which exceeds the benefit amount such Covered Person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that Covered Person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

## **Reporting of Claims**

A claim must be submitted to the Claims Administrator in writing. It must give proof of the nature and extent of the loss. Emory has claim forms.

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

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. But unless you are legally incapacitated, no later than 2 years after the deadline.

## **Payment of Benefits**

Benefits will be paid as soon as the necessary proof to support the claim is received. All Benefits are payable to Core Providers or In-Network Providers or to you. However, this Plan has the right to pay any health Benefits to the service provider. This Plan may pay up to \$ 1,000 of any benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

## **Records of Expenses**

Keep complete records of the expenses of each Covered Person. They will be required when a claim is made. In particular, make sure to keep the following:

- Names of Physicians, Dentists and others who furnish services;
- Dates expenses are incurred; and
- Copies of all bills and receipts

## **Legal Action**

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

## **Filing an Appeal**

### **Eligibility for Coverage, Participation and Contributions**

The Plan Administrator will make all determinations relating to eligibility for coverage, participation, contributions or other administrative aspects of the Plan. You may file a claim with regard to any of these administrative issues with the Plan Administrator and appeal adverse claim decisions to the Plan Administrator.

### **How to File Your Appeal**

To appeal an adverse administrative decision, file your appeal, in writing via regular mail to:

Emory University  
Employee Benefits Department  
Official Appeal  
1599-001-1AP  
1599 Clifton Road NE  
Atlanta, Georgia 30322

or by fax to:

Emory University  
Employee Benefits Department  
Official Appeal  
(404) 727-7145

Under no circumstances will an appeal be accepted via e-mail. Your appeal request should include your name, employee number and any other comments, documents, records and/or other information you would like to have considered, whether or not submitted originally. You will have 180 days from receiving notification of a denial of eligibility for coverage, participation and/or contributions to file an appeal with the Plan Administrator. Your appeal will be acknowledged within 15 working days of receipt. A representative of the Plan Administrator may call you to obtain records and/or other pertinent information in order to respond to your appeal. You will be notified of a decision with regard to your appeal not later than 30 days after the appeal is received. This period may be extended up to 15 days and a representative of the Plan Administrator will contact you to indicate a delay with regard to a determination of your appeal.

If you are dissatisfied with an appeal decision, you may file a second-level appeal with the Plan Administrator within 60 days of receipt of the decision with regard to your first appeal. The Plan Administrator will notify you of the decision with regard to your second appeal not later than 45 days after the appeal is received.

### **Health Plan Appeals For Claims Payment**

You may file claims for Plan Benefits with the Claims Administrator and appeal adverse claim decisions, either yourself or through an authorized representative. To file an appeal:

For Medical claims:

Aetna

Attn: National Account CRT

P. O. Box 14463  
Lexington, KY 40512  
Fax (859) 455-8650

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

### **Urgent Care Claims**

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is a claim involving urgent care, you will be notified of the decision not later than 72 hours after the claim is received.

“A claim involving urgent care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or in the opinion of a physician with knowledge of the Covered Person’s medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

### **Other Claims (Pre-Service and Post-Service)**

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period. For example, the time permitted may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims that name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an

urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

### **Ongoing Course of Treatment**

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce Benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

You may file an appeal in writing. The denial notice will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call at the toll-free phone number on the front of your ID card. Your request should include the group name (that is, Emory), your name, Social Security Number or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

Your appeal will be acknowledged within five working days of receipt. A representative of the Claims Administrator may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to the Claims Administrator. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim is a claim involving urgent care, an expedited appeal may be initiated by a telephone call to Member Services. The Claims Administrator's Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second level appeal with the Claims Administrator. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with the Claims Administrator within 60 days of receipt of the level one appeal

decision. The Claims Administrator will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

### Exhaustion of Process

You must exhaust the applicable level one and level two processes of the appeal procedure before you:

- Contact the Department of Insurance to request an investigation of a complaint or Appeal; or
- File a complaint or Appeal with the Department of Insurance; or
- Establish litigation or administrative proceedings;

regarding an alleged breach of the policy terms or any matter within the scope of the appeals procedure.

### Retrospective Record Review

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of healthcare services. The Claims Administrators' effort to manage the services provided to the Covered Persons includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

### Concurrent Review and Discharge Planning

The following items apply if the Plan requires certification of any confinement, services, supplies, procedures, or treatments:

#### Concurrent Review

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

#### Discharge Planning

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

### Newborns' and Mothers' Health Protection Act

Under federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse

midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, Plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan or issuer may not, under federal law, require that you, your Physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceeds 48 hours (or 96 hours). For information on precertification, contact the Claims Administrator.

## **Notice regarding Women's Health and Cancer Rights Act**

Under this Plan, coverage will be provided to a Covered Person who is receiving Benefits for a Medically Necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

- 1) reconstruction of the breast on which a mastectomy has been performed;
- 2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- 3) prostheses; and
- 4) treatment of physical complications of all stages of mastectomy, including lymph edemas.

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 for the mastectomy.

If you have any questions about the coverage of mastectomies and reconstructive surgery under the Plan, please contact the Member Services number on your ID card.

## **Summary of ERISA Information**

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). Emory has determined that this information is the Summary Plan Description required by ERISA.

Employer Identification Number: 58-0566256

Plan Number: 502

Type of Plan: Welfare (health care benefits)

Type of Administration:

Administrative Services Contract with:

Aetna Life Insurance Company

151 Farmington Avenue

Hartford, CT 06156

Plan Administrator:

Emory University  
Attn: Vice President for Human Resources  
1599 Clifton Road, First Floor  
Atlanta, GA 30322

Agent for Service of Legal Process:  
Emory University  
Office of the General Counsel  
201 Dowman Drive  
101 Administration Building  
Atlanta, GA 30322

End of Plan Year: December 31st

Source of Contributions: You and Emory Share in the cost of this Plan.

Procedure for Amending the Plan: Emory may amend the Plan from time to time by a written instrument signed by a senior officer of Emory University

## **ERISA Rights**

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

## **Continue Group Health Plan Coverage**

You may be able to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

In accordance with federal law (PL 99-272) as amended, Covered Persons have the right to continue their health expense coverage under certain circumstances. You or your dependents

may continue any health expense coverage then in effect, if coverage would terminate for the reasons specified in sections A or B below. You and your dependents may be required to pay up to 102% of the full cost to the Plan of this continued coverage or as to a disabled individual whose coverage is being continued for 29 months in accordance with section A, up to 150% of the full cost to the Plan of this continued coverage for any month after the 18th month. Subject to the payment of any required contribution, health expense coverage may also be provided for any dependents you acquire while the coverage is being continued. Coverage for these dependents will be subject to the terms of this Plan regarding the addition of new dependents.

Continuation shall be available as follows:

- A. Continuation of Coverage on Termination of Employment or Loss of Eligibility. If your coverage would terminate due to termination of your employment for any reason other than gross misconduct or your loss of eligibility under this Plan due to a reduction in the number of hours you work, you may elect to continue coverage for yourself and your dependents or your dependents may each elect to continue their own coverage. This election must include an agreement to pay any required contribution. You or your dependents must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date Emory informs you or your eligible dependents of any rights under this section. Coverage will terminate on whichever of the following is the earliest to occur:
- The end of an 18-month period after the date of the event that would have caused coverage to terminate.
  - The end of a 29-month period after the date of the event that would have caused coverage to terminate, but only if prior to the end of the above 18-month period, you or your dependent provides notice to Emory, in accordance with section D below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event that would have caused coverage to terminate. Coverage may be continued for the individual determined to be disabled and for any family member (employee or dependent) of the disabled individual for whom coverage is already being continued and for your newborn or newly adopted child who was added after the date continued coverage began.
  - The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to you under another Plan sponsored by Emory.
  - The date any required contributions are not made.
  - The first day after the date of the election that the individual becomes covered under another group health Plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health Plan.
  - The first day after the date of the election that the individual becomes enrolled in benefits under Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.
  - As to all individuals whose coverage is being continued in accordance with the terms of the second bulleted item above, the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled individual whose coverage is being so

continued is no longer disabled but in no event shall such coverage terminate prior to the end of the 18-month period described in the first bulleted item above.

B. Continuation of Coverage under Other Circumstances. If coverage for a dependent would terminate due to:

- your death;
- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated;
- the dependent's ceasing to be a dependent child as defined under this Plan; or
- the dependent's loss of eligibility under this Plan because you become entitled to benefits under Medicare

the dependent may elect to continue his or her own coverage. The election to continue coverage must be made within 60 days of the later to occur of the date coverage would terminate and the date Emory informs your dependents, subject to any notice requirements in section D below, of their continuation rights under this section. The election must include an agreement to pay any required contribution.

C. Coverage for a dependent will terminate on the first to occur of:

- The end of a 36-month period after the date of the event that would have caused coverage to terminate.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to your dependents under another Plan sponsored by Emory.
- The date any required contributions are not made.
- The first day after the date of the election that the dependent becomes covered under another group health Plan. However, continued coverage will not terminate until such time that the dependent is no longer affected by a preexisting condition exclusion or limitation under such other group health Plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

D. Multiple Qualifying Events - If coverage for you or your dependents is being continued for a period specified under section A, and during this period one of the qualifying events under the above section B occurs, this period may be increased. In no event will the total period of continuation provided under this provision for any dependent be more than 36 months. Such a qualifying event, however, will not act to extend coverage beyond the original 18-month period for any dependents (other than a newborn or newly adopted child) who were added after the date continued coverage began.

E. Notice Requirements

- If coverage for you or your dependents:
  - is being continued for 18 months in accordance with section A; and
  - it is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event in section A that would have caused coverage to terminate you or your dependent must notify Emory of such determination within 60 days after the date of the determination and within 30 days after the date of any final determination that you or your dependent is no longer disabled.
- If coverage for a dependent would terminate due to:
  - your divorce;

- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated; or
- your dependent's ceasing to be a dependent child as defined under this Plan you or your dependent must provide notice to Emory of the occurrence of the event. This notice must be given within 60 days after the later of the occurrence of the event and the date coverage would terminate due to the occurrence of the event. If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

F. Continuation of Coverage During an Approved Leave of Absence Granted to Comply with Federal Law – If any coverage Emory allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on approved FMLA leave. Coverage will not continue beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date Emory determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another Plan sponsored by Emory.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate. If coverage terminate because your approved FMLA leave is deemed terminated by Emory, you may, on the date of such termination, be eligible for continuation under federal law on the same terms as though your employment terminated, other than for gross misconduct, on such date. .

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work and not on an approved FMLA leave.

If you return to work for Emory following the date Emory determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date Emory determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

## **Prudent Actions by Plan Fiduciaries**

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

## **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for Benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

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

### **Assistance with Your Questions**

If you have any questions about the Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

## Definitions

When used in this SPD, the following words and phrases have the meaning explained herein.

**Active Employee** - means an employee who is working as a regular full-time or half-time (at least 20 hours per week) employee or as a temporary full-time employee on an assignment at Emory scheduled for at least six months.

**Acupuncture Services** - Services for pain therapy when both of the following are true:

- The service is performed by a provider in the provider's office; and
- The provider is a licensed acupuncturist.

**Aggregate Out-Of-Pocket Maximum** - The combination of each family member's out of pocket expense is accumulated toward the maximum

**Allowable Expense** - means a health care service or expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example a POS), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

- If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room (unless the patient's stay in the private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage of Hospital private rooms) is not an allowable expense.
- If a person is covered by 2 or more Plans that compute their benefit payments on the basis of Reasonable or Recognized Charges, any amount in excess of the highest of the Reasonable or Recognized Charges for a specific benefit is not an allowable expense.
- If a person is covered by 2 or more Plans that provide benefits or services on the basis of Negotiated Charges, an amount in excess of the highest of the Negotiated Charges is not an allowable expense, unless the secondary Plan's provider's contract prohibits any billing in excess of the provider's agreed upon rates.
- If a person is covered by one Plan that calculates its benefits or services on the basis of Reasonable or Recognized Charges and another Plan that provides its benefits or services on the basis of Negotiated Charges, the primary Plan's payment arrangements shall be the allowable expense for all the Plans.
- The amount a benefit is reduced by the primary Plan because a Covered Person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

**Alternate Facility** - A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services;
- Emergency health services; or

- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Behavioral Health Care on an outpatient or inpatient basis.

**Behavioral Health Care** - Treatment of Mental Health and/or substance abuse disorders. Services include assessment, diagnosis, treatment planning, medication management, psychotherapy and psychological testing.

**Benefits** - Your right to payment for Covered Health Services that are available under the Plan. Your right to benefits is subject to the terms, conditions, limitations and exclusions of the Plan.

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

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

**Brand Name Medication** - A Prescription Drug that is protected by trademark registration.

**Calendar Year Deductible** - The amount of Covered Medical Expenses you pay each plan year before Benefits are paid. There is a calendar year Deductible that applies to each person and also a Family Deductible Limit.

**Care Advocate (UBH)** - The qualified person you speak with when calling United Behavioral Health Services to obtain referrals to providers for Mental Health and substance abuse care and treatment

**Claims Administrator** - The companies (including affiliates) that provides certain claim administration services for the Plan including Aetna, Medco and United Behavioral Health (UBH).

**Claim Determination Period** - The calendar year.

**Coinsurance** - A percentage of the charge that you are responsible for, after Deductibles.

**Companion** - A person whose presence as a companion or caregiver is necessary to enable an NME Patient:

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

**Congenital Anomaly** - A physical developmental defect that is present at birth and is identified within the first twelve months of birth.

**Convalescent Facility** - An institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury: professional nursing care by a R.N. or by a L.P.N.

directed by a full-time R.N.; and physical restoration services to help patients to meet a goal of self-care in daily living activities;

- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.;
- Is supervised full-time by a physician or R.N.;
- Keeps a complete medical record on each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mentally retarded, for Custodial Care or educational care, or for care of mental disorders; and
- Makes charges.

**Copay or Copayment** - A flat fee charged to a person at the time services are rendered for services such as office visits and Prescription Drugs.

**Core Network** - Providers give you the maximum benefit available under the Plan with lower Copays, Coinsurance and Deductibles. To locate participating Core physicians and facility, visit [www.aetna.com/docfind/custom/emory](http://www.aetna.com/docfind/custom/emory) or call 800-847-9026.

**Cosmetic Procedures** - Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator on behalf of this Plan.

**Covered Health Service(s)** - Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, Mental Illness, substance abuse, or symptoms thereof.

**Covered Medical Expense(s)** - The cost of Covered Health Services(s) that are included in this Plan when calculating Benefits payable.

**Covered Person** - This is either the employee, retired employee, or an enrolled dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

**Custodial Care** - Services and supplies furnished to a Covered Person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The Covered Person does not have to be disabled. Such services and supplies are Custodial Care without regard to:

- by whom they are prescribed;
- by whom they are recommended; or
- by whom or by which they are performed.

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

**Deductible** - The amount of Covered Expense you must pay each year before any Plan Benefits begin.

**Dentist** - A legally qualified Dentist. Also, a physician who is licensed to do the dental work he or she performs.

**Durable Medical and Surgical Equipment** - No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

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

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

**Emergency Care** - The treatment given in a Hospital's emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

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

**Emory** - Shall mean Emory University and its' schools, operating divisions and affiliates and any/all entities controlled by Emory University either directly or indirectly, including but not limited to, the Carter Center, Inc., Emory Healthcare Inc., Wesley Woods Center of Emory University Inc., Emory Children's Center Inc., and The Emory Clinic Inc. Employees of Emory Specialty Associates, LLC are not eligible for coverage under this Plan.

**Excluded Amount** - A charge made by a provider that is not covered under the Plan.

**Family Deductible Limit** - If Covered Medical Expenses incurred in a Plan year by you and your dependents and applied against the separate Calendar Year Deductible equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductible for the rest of that calendar year.

**Federal Legend Drug** - Any drug that requires a prescription.

**Generic Drug** - A Prescription Drug that is not protected by trademark registration but is produced and sold under the chemical formulation name.

**Home Health Care Agency** - This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group that makes policy (this group must have at least one physician and one R.N.); and
- has full-time supervision by a physician or a R.N.; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

**Home Health Care Plan** - This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be prescribed in writing by the attending physician and an alternative to confinement in a Hospital or Convalescent Facility.

**Hospice Care** - This is care given to a Terminally Ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

**Hospice Care Agency** - This is an agency or organization that has Hospice Care available 24 hours a day and meets any licensing or certification standards set forth by the jurisdiction where it is located and which:

- Provides skilled nursing services, medical social services, and psychological and dietary counseling.
- Provides or arranges for other services, including services of a physician; physical and occupational therapy; part-time home health aide services that mainly consist of caring for Terminally Ill persons; and inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel including at least: (a)one physician; (b)one R.N. and (c)one licensed or certified social worker employed by the Hospice Care Agency.
- Establishes policies governing the provision of Hospice Care.
- Assesses the patient's medical and social needs and develops a Hospice Care Program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the Hospice Care Agency. Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

**Hospice Care Program** - This is a written plan of Hospice Care that is established by and reviewed from time to time by a physician attending the Covered Person; and appropriate personnel of a Hospice Care Agency. It is designed to provide palliative and supportive care to Terminally Ill persons and supportive care to their families. A Hospice Care Program includes an assessment of the person's medical and social needs and a description of the care to be given to meet those needs.

**Hospice Facility** - This is a facility, or distinct part of one, which:

- Mainly provides inpatient Hospice Care to Terminally Ill persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians. At least one of them must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a R.N.
- Has a full-time administrator.

**Hospital** - This is a place that:

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

**In-Network Providers** - Providers that are part of, or who have contracts with the Claim Administrators. To locate a participating physician or facility, visit [www.aetna.com/docfind/custom/emory](http://www.aetna.com/docfind/custom/emory) or call 800-847-9026. For UBH call 877-237-8575 and Medico visit [www.medco.com](http://www.medco.com).

**Lifetime Maximum Benefit** - This is the most that will be payable by the Plan for any person in his or her lifetime. The only exception is once a person reaches this maximum, up to \$100,000 in Benefits are eligible to be paid by the Plan each calendar year if they remain a Covered Person.

**L.P.N.** - This means a licensed practical nurse.

**Mail Order Pharmacy** - An establishment where Prescription Drugs are legally dispensed by mail.

**Medically Necessary** - Services that are appropriate and consistent with the diagnosis in accordance with acceptable medical standards. The Claims Administrator reserves the right to determine whether a service or supply is Medically Necessary. The fact that a Physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary. The Claims Administrator considers a service Medically Necessary if it is:

- Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- Compatible with the standards of acceptable medical practice in the United States;
- Not provided solely for the Covered Person's convenience or the convenience of the Physician, health care provider or Hospital;
- Not primarily Custodial Care; and
- Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

**Mental Disorder** - A mental disorder includes, but is not limited to:

- Alcoholism and drug abuse
- Schizophrenia
- Bipolar disorder
- Pervasive Mental Developmental Disorder (Autism)
- Panic disorder
- Major depressive disorder

- Psychotic depression
- Obsessive compulsive disorder

For the purposes of Benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

**Mental Health Disease and Treatment** - Treatment for a sickness that is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This is a disease commonly understood to be a Mental Disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker.

**Morbid Obesity** - This means a certain Body Mass Index that is calculated by the Claim Administrator to determine eligibility of certain supplies and services.

**Negotiated Charge** - This is the maximum charge a Core Network or In-Network Provider has agreed to make as to any service or supply for the purpose of the Benefits under this Plan.

**Non-Occupational Disease or Injury** - A non-occupational disease is a disease that does not arise out of (or in the course of) any work for pay or profit or result in any way from a disease that does. A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

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

**Orthodontic Treatment** - This is any medical service or supply or dental service or supply that is furnished to prevent, diagnose or to correct a misalignment of the teeth, bite or of the jaws or jaw joint relationship, whether or not for the purpose of relieving pain. Not included is the installation of a space maintainer or a surgical procedure to correct malocclusion.

**Out-of-Network Providers** - Providers who are not participating/contracted with the Claims Administrator. Out of pocket will be higher when seeking care from these providers.

**Out-of-Pocket Maximum** - The most you will have to pay per person, per year for certain covered expenses. It includes the Deductible and most Coinsurance amounts. It does not include Coinsurance amounts for Behavioral Health Care or any Copayments, such as those for office or emergency room visits or Prescription Drugs. Once you have paid the Out-of-Pocket Maximum expense amount, the Plan pays 100% of the Covered Person's covered expenses up to the Lifetime Maximum Benefit for the rest of the calendar year

**Pharmacy** - An establishment where Prescription Drugs are legally dispensed.

**Physician** - This means a legally qualified doctor.

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

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

If the contract includes both medical and dental coverage, those coverages will be considered separate Plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy Plans. In turn, the dental coverage will be coordinated with other dental Plans. The Plan described in this summary is the Emory POS Health Plan, the “Plan”.

**Plan Administrator** - Emory University Human Resource Department

**Preferred Pharmacy** - A pharmacy, including a Mail Order Pharmacy that is party to a contract with Medco to dispense drugs to a Covered Person while the contract remains in effect and while such a pharmacy dispenses a Prescription Drug under the terms of its contract with Medco.

**Prescription Drugs** - Any of the following:

- A drug, biological, compounded prescription or contraceptive device that, by Federal Law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes that are purchased to administer a covered injectable Prescription Drug.
- Disposable diabetic supplies.

**Primary Care Physician** - This is a person who is responsible for coordinating all of a covered participant’s medical care.

**Psychologist** - This is a person who specializes in clinical psychology and fulfills one of the following requirements: A person licensed or certified as a psychologist or a member or fellow of the American Psychological Association, if there is not government licensure or certification required.

**Reasonable or Recognized Charge** - This only applies to Out-of-Network claims. Only that part of a charge that is reasonable is covered. The reasonable charge for a service or supply is

the lowest of the provider's usual charge for furnishing it, and the charge the Claims Administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and the charge the Claims Administrator determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply, the complexity; the degree of skill needed; the type of specialty of the provider; the range of services or supplies provided by a facility; and the prevailing charge in other areas will be taken into consideration.

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

**R.N.** - This means a registered nurse.

**Semiprivate Rate** - This is the charge for board and room that an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, the Claims Administrator will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

**Specialist** - A Physician who practices in any generally accepted medical or surgical sub-specialty and is providing other than routine medical care. A Physician who practices in such a sub-specialty and is providing routine medical care (such as could be given by a Primary Care Physician), will not be considered a Specialist for purposes of applying this Plan's Copay provisions.

**Surgery Center** - This is a freestanding ambulatory surgical facility that:

- Meets licensing standards
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of Physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to Physicians who practice surgery in an area Hospital and Dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
- Is equipped and has trained staff to handle medical emergencies.
- Has a physician trained in cardiopulmonary resuscitation; and
- Has a defibrillator, a tracheotomy set and a blood volume expander.

- Has a written agreement with a Hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by Physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

**Terminally Ill** - This is a medical prognosis of 6 months or less to live.

**Treatment Facility (Alcoholism Or Drug Abuse)** - This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse;
- Makes charges;
- Meets licensing standards;
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a Physician;
- Provides, on the premises, 24 hours a day:
  - Detoxification services needed with its effective treatment program.
  - Infirmary-level medical services.
- Provides, or arranges with a Hospital in the area for, any other medical services that may be required;
- Provides supervision by a staff of Physicians; and
- Provides skilled nursing care by licensed nurses who are directed by a full-time R.N.

**Treatment Center (Mental Disorder)** - A facility that provides a program of effective mental health and substance abuse treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It is staffed by psychiatric Physicians involved in care and treatment.
- Is not mainly a school or a custodial, recreational or training institution
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and board;
  - Evaluation, diagnosis; counseling;
  - Referral and orientation to specialized community resources.
  - Infirmary-level medical services;
- Provides, or arranges with a Hospital in the area for, any other medical service that may be required;
- Full-time supervision by a psychiatrist who is responsible for patient care and is there regularly;
- Psychiatric social work and nursing services at all times; and.
- Skilled nursing care by licensed nurses who are supervised by a full-time R.N at all times.

**Urgent Care Provider** - This is a freestanding medical facility that provides unscheduled medical services to treat an urgent condition if the Covered Person's physician is not reasonably available. It is not the emergency room or outpatient department of a Hospital.