



*The* **BANK**  
*of* **NEW YORK**

## **AETNA HMO**

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This booklet is your guide to the benefits available through the Aetna HMO\* Plan (“the Plan”). Please read it carefully and refer to it when you need information about how the Plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about many of the special programs available to you as a Plan participant.

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

### ***\*\*\*Tips for New Plan Participants\*\*\****

- Keep this booklet where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Post your Primary Care Physician’s name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See page 21 for emergency care guidelines.

\*As used in this booklet, “HMO” refers to HMO-type benefits that are administered by Aetna and self-insured by The Bank of New York.

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## How the Plan Works

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

Each participant in the Plan must select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system and will coordinate and monitor your overall care.

### The Primary Care Physician

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

The referral is important because:

- It is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment; and

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

### Primary and Preventive Care

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

## Specialty and Facility Care

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

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

To avoid costly and unnecessary bills for specialty and facility care, follow these steps:

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

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

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

### ***Specialist as Principal Physician Direct Access Program***

If you have a serious or complex medical condition, you may need ongoing specialty care. A “serious or complex medical condition” is generally a life-threatening, degenerative or disabling condition or disease such as AIDS, cancer, emphysema, an organ failure that may require a transplant or diabetes with target organ involvement.

The Specialist as Principal Physician Direct Access Program is a voluntary program. Eligibility is based upon the nature of your medical condition, your need for continuing specialty care and a specialist’s willingness to serve as your principal physician for treatment of the condition. Enrollment in the program must be approved by Aetna. Once you are enrolled, a case manager will be available to answer questions about the features of the program, to assist with any necessary authorizations or precertifications and to facilitate communications between your PCP and the specialist treating your condition.

If you are interested in enrolling in the Specialist as Principal Physician Direct Access Program, contact Member Services at the toll-free number shown on your ID card and ask to be transferred to a disease management representative.

### **Provider Information**

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

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

### **Your ID Card**

When you enroll in the Plan, you and each enrolled member of your family receive a member ID card.

Your ID card lists the telephone number of the Aetna PCP you have chosen. If you change your PCP, you will automatically receive a new card displaying the change.

Always carry your ID card with you. It identifies you as a Plan participant when you receive services from participating providers or when you receive emergency services at nonparticipating facilities. Your ID card should also be used when you obtain prescription drugs from a participating pharmacy. If your card is lost or stolen, please notify Aetna immediately.

## Copayment Schedule

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

Type of Service or Supply	Benefit Level
<b>Maximum</b>	No lifetime maximum
<b>Primary and Preventive Care</b>	
PCP Office Visits	\$20 copay per visit
After Hours/Home Visits/Emergency Visits	\$20 copay per visit
Routine Examinations	\$20 copay per visit
Routine Child and Well-Baby Care	\$20 copay per visit
Immunizations	\$20 copay per visit
Routine Gynecological Exams	\$20 copay per visit - direct access (no referral) to participating providers for one routine exam and Pap smear per year
Routine Mammogram	\$20 copay - one annual mammogram for women age 40 and over
Routine Eye Examinations	\$20 copay per visit - direct access (no referral) to participating providers for periodic routine exams
Eyeglasses/Contact Lenses	Discounts available through Vision One Discount Program
Routine Hearing Screenings	Covered when performed as part of a routine exam by PCP. Subject to \$20 office visit copay.
Hearing Aids	Not covered
<b>Specialty and Outpatient Care</b>	
Office Visits	\$20 copay per visit
Prenatal Care	\$20 copay for the first OB visit
Infertility Services (diagnosis and treatment of the underlying cause only)	\$20 copay per visit
Advanced Reproductive Technology	Not covered
Allergy Testing	\$20 copay per visit
Allergy Treatment Routine injections at PCP’s office, with or without physician encounter	\$20 copay per visit
X-rays and Lab Tests	\$20 copay
Therapy (speech, occupational, physical)	\$20 copay per visit – 60 consecutive days per illness or injury
Home Health Care	No copay
Hospice Care	No copay
Prosthetic Devices	No copay – some prosthesis must be approved in advance by Aetna

Type of Service or Supply	Benefit Level
<b>Inpatient Services</b>	
Room and Board	\$240 copay per admission (waived if readmitted within 90 days)
X-rays and Lab Tests	Subject to room and board copay
Private Duty Nursing	Not covered unless medically necessary and approved in advance by Aetna - no copay
Special Care Units	Subject to room and board copay
Maternity Care	Subject to room and board copay
Skilled Nursing Facilities	\$240 copay per admission (waived if readmitted within 90 days)
Hospice Facility	\$240 copay per admission
<b>Surgery and Anesthesia</b>	
Inpatient Surgery	Subject to room and board copay
Outpatient Surgery	\$100 copay - outpatient facility \$20 copay - specialist's office
<b>Mental and Nervous Conditions</b>	
Inpatient Treatment	35 days per year - \$240 copay per admission
Outpatient Treatment	20 visits per year - \$25 copay per visit
<b>Treatment of Alcohol and Drug Abuse</b>	
Inpatient Detoxification	\$240 copay per admission
Inpatient Rehabilitation	30 days per year - \$240 copay per admission
Outpatient Detoxification	60 days per year - \$20 copay per visit
Outpatient Rehabilitation	60 visits per year - \$20 copay per visit
<b>Prescription Drugs</b>	
	No annual maximum
Retail (34-day supply)	After \$100/member (\$200/family) deductible: \$10 copay – generic drugs \$20 copay – brand-name formulary drugs \$30 copay – brand-name non-formulary drugs
Mail Order (90-day supply)	No deductible \$20 copay – generic drugs \$30 copay – brand-name formulary drugs \$60 copay – brand-name non-formulary drugs
<b>Emergency Care</b>	
Emergency Room	\$35 copay (waived if admitted)
Ambulance	No copay when medically necessary

## Your Benefits

**Although a specific service may be listed as a covered benefit, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of your illness or condition. Certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval.**

**Medically necessary** means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards. To be medically necessary, the service or supply must:

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

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

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

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

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

## **Primary and Preventive Care**

The following types of benefits are available through your participating PCP when medically necessary.

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your PCP.
- Well-child care from birth, including immunizations and booster doses, as recommended by your child's PCP.
- Health education counseling and information.
- One routine gynecological examination and Pap smear performed by your PCP every year. You may also visit a participating gynecologist for a routine GYN exam and Pap smear without a referral.
- One routine mammogram every year for female Plan participants age 40 or over, or when medically necessary. You must obtain a referral for the mammogram from your PCP or gynecologist, or obtain authorization from Aetna.
- Routine immunizations (except those required for travel or work).
- Periodic eye examinations. You may visit a participating provider without a referral as follows:
  - If you wear eyeglasses or contact lenses:*
    - age 1-18 years - one exam every 12 months.
    - age 19 or over - one exam every 24 months.
  - If you do not wear eyeglasses or contact lenses:*
    - age 1-44 years - one exam every 36 months.
    - age 45 or over - one exam every 24 months.
- Routine hearing screenings performed by your PCP as part of a routine physical examination.
- Injections, including routine allergy desensitization injections.

## **Specialty and Outpatient Care**

The Plan covers the following specialty and outpatient services:

- Participating specialist office visits by appointment *with prior written or electronic referral*.
  - Participating specialist consultations, including second opinions.
  - Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by Aetna.
  - Preoperative and postoperative care.
  - Casts and dressings.
  - Radiation therapy.
  - Cancer chemotherapy.
  - Short-term speech, occupational (except vocational rehabilitation and employment counseling) and physical therapy for treatment of non-chronic conditions and acute illness or injury.
  - Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
  - Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
  - Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
  - Diagnostic, laboratory and X-ray services.
  - Emergency care including ambulance service - 24 hours a day, 7 days a week (see “In Case of Emergency”).
  - Home health services provided by a participating home health care agency, including:
    - skilled nursing services provided or supervised by an RN.
    - services of a home health aide for skilled care.
    - medical social services provided or supervised by a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.
  - Outpatient hospice services for a Plan participant who is terminally ill, including:
    - counseling and emotional support.
    - home visits by nurses and social workers.
    - pain management and symptom control.
    - instruction and supervision of a family member.
- Note:** The Plan does *not* cover:
- bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
  - homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
  - respite care when the patient’s family or usual caretaker cannot, or will not, attend to the patient’s needs.
- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, removal of tumors and odontogenic cysts).
  - Reconstructive breast surgery following a mastectomy, including:
    - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,

- surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
- physical therapy to treat the complications of the mastectomy, including lymphedema.
- Infertility services to diagnose and treat the underlying medical cause of infertility. You may obtain the following **basic** infertility services from a participating gynecologist or infertility specialist **without** a referral from your PCP:
  - initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
  - evaluation of ovulatory function,
  - ultrasound of ovaries at an appropriate participating radiology facility,
  - postcoital test,
  - hysterosalpingogram,
  - endometrial biopsy, and
  - hysteroscopy.

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

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

- ovulation induction cycles (bloodwork and ultrasounds), subject to a lifetime maximum of 6 cycles,
  - artificial insemination, subject to a lifetime maximum of 6 attempts, and
  - infertility surgery (diagnostic or therapeutic).
- **Coverage for all other infertility treatment and services is specifically excluded as described under *Plan Exclusions and Limitations*.**
  - Chiropractic services. Subluxation services must be consistent with Aetna’s guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist.
  - Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Certain prosthetics require preauthorization by Aetna.
  - One wig or hairpiece per year. The wig or hairpiece must be prescribed by a physician for hair loss due to injury, disease or the treatment of a disease. The Plan does **not** cover wigs or hairpieces for androgenetic alopecia (male pattern baldness).
  - Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury, and preauthorized by Aetna.

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

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

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

## **Inpatient Hospital and Extended Care Facility**

If you are hospitalized by a participating PCP or specialist (with prior referral except in emergencies), you are eligible for the benefits listed below if the services and treatment received are medically necessary. See “Mental Health/Substance Abuse” for inpatient mental health and substance abuse benefits.

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

network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

## **Maternity**

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

You do not need a referral from your PCP for visits to your participating obstetrician

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

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

## **Mental Health/Substance Abuse**

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

### ***Treatment of Mental or Nervous Conditions***

The Plan covers the following services for mental health treatment:

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

### ***Treatment of Alcohol and Drug Abuse***

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

- **Inpatient** medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in a non-hospital residential facility, appropriately licensed, upon referral by your participating provider.
- **Outpatient** visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.  
Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

## **Prescription Drugs**

The Plan pays, subject to any limitations specified under *Your Benefits*, the cost incurred for outpatient prescription drugs that are obtained from a participating pharmacy. You must present your ID card and make the copayment shown in the “Copayment Schedule” for each prescription at the time the prescription is dispensed.

If your physician prescribes a brand-name drug when a generic is available, and specifies “Dispense as written” (DAW), you are responsible for the copayment shown in the “Copayment Schedule.” If, however, you request a brand-name drug when a generic drug is available, you must pay the difference in cost (if any) between the brand-name drug and the generic drug, plus the applicable copayment.

The Plan covers the costs of prescription drugs, in excess of the copayment, that are:

- Medically necessary for the care and treatment of an illness or injury, as determined by Aetna;
- Prescribed in writing by a physician who is licensed to prescribe federal legend prescription drugs or medicines; and
- Not listed under “Prescription Drug Exclusions and Limitations,” below.

Each prescription is limited to a maximum 34-day supply, with refills as authorized by your physician (but not to exceed one year from the date originally prescribed). Non-emergency prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name products where permitted by law.

Coverage is based upon Aetna’s formulary. The formulary includes both brand-name and generic drugs and is designed to provide access to quality, affordable outpatient prescription drug benefits. You can reduce your copayment by using a covered generic drug or a covered brand-name drug that appears on the formulary. Your copayment will be highest if your physician prescribes a covered brand-name drug that does not appear on the formulary

## **Maintenance Drugs**

Participants in the Plan who must take maintenance drugs for a chronic condition may be able to obtain up to a 90-day supply of their maintenance drug through the mail order pharmacy, if

authorized by their physician. Ask the pharmacist at your participating pharmacy whether your maintenance drug is on the list of drugs approved by Aetna for a 90-day supply. If it is included on the list, ask your physician to give you two prescriptions - one for a 34-day supply that you can obtain immediately from your participating retail pharmacy, and the second for your 90-day maintenance supply. The ongoing supply must be obtained from a participating retail or mail order pharmacy.

The copayment shown in the “Copayment Schedule” will apply to each purchase of maintenance drugs.

### ***Mail Order Drugs***

Participants in the Plan who must take a drug for more than 34 days may obtain a 90 day supply of the drug at a participating mail order pharmacy, if authorized by their physician. The maximum quantity is for a 90-day supply. The minimum quantity is a 35 day supply. The copayment shown in the “Copayment Schedule” will apply to each mail order purchase.

### ***Precertification***

Your pharmacy benefits plan includes Aetna’s precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-authorized by Aetna’s Pharmacy Management Precertification Unit before they will be covered. Only your physician can request prior authorization for a drug.

The precertification program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, cost information includes any manufacturer rebate arrangements between Aetna and the manufacturers of certain drugs on Aetna’s Formulary.

The drugs requiring precertification are subject to change. Call Member Services or visit Aetna’s website for the current Precertification List.

### ***Emergency Prescriptions***

You may not have access to a participating pharmacy in an emergency or urgent care situation, or if you are travelling outside of the Plan’s service area. If you must have a prescription filled in such a situation, the Plan will reimburse you as follows:

### ***Non-Participating Pharmacy***

Coverage for items obtained from a non-participating pharmacy is limited to items connected to covered emergency or out-of-area urgent care services. You must pay the pharmacy directly for the

cost of the prescription. You are responsible for submitting a written request for reimbursement to Aetna, accompanied by the receipt for the prescription. Aetna will review your request and determine whether the event meets the qualifications for reimbursement. If approved, you will be reimbursed for 100% of the cost, minus any applicable copayment.

### **Participating Pharmacy**

When you obtain an emergency or urgent care prescription at a participating pharmacy (including an out-of-area participating pharmacy), you must pay the copay. Aetna will not reimburse you if you submit a claim for a prescription obtained at a participating pharmacy.

### ***Covered Drugs***

The Plan covers the following:

- Outpatient prescription drugs when prescribed by a provider who is licensed to prescribe federal legend drugs or medicines, subject to the terms, limitations, and exclusions described in this booklet.
- Insulin.
- Diabetic supplies, as follows: diabetic needles and syringes.
  - alcohol swabs.
  - test strips for glucose monitoring and/or visual reading.
  - diabetic test agents.
  - lancets (and lancing devices).
- FDA-approved prescription drugs when the off-label use of the drug has not been approved by the FDA to treat the condition in question, provided that:
  - the drug is recognized for treatment of the condition in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or
  - the safety and effectiveness of use for the condition has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.
- Injectable drugs used in the treatment of infertility, up to 50% of the contracted rate per prescription or refill. Coverage includes (subject to change by Aetna):
  - urofollitropin,
  - menotropin,
  - human chorionic gonadotroin, and
  - progesterone.

### ***Prescription Drug Exclusions and Limitations***

#### **Exclusions**

The following services and supplies are not covered by the Plan and a medical exception is *not* available for coverage:

- Any drug that does not, by federal or state law, require a prescription order (such as an over-the-counter drug), even when a prescription is written.
- Charges for the administration or injection of a prescription drug or insulin.
- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth, including (but not limited to) health and beauty aids.
- Any prescription for which the actual charge to you is less than the copayment.
- Any prescription for which no charge is made to you.
- Insulin pumps or tubing for insulin pumps.
- Needles and syringes, except diabetic needles and syringes
- Medication which is to be taken by you or administered to you, in whole or part, while you are a patient in a licensed hospital or similar facility.
- Take home prescriptions dispensed from a hospital pharmacy upon discharge from the hospital, unless the hospital pharmacy is a participating retail pharmacy.
- Any medication that is consumed or administered at the place where it is dispensed.
- Immunization or immunological agents, including:
  - biological sera.
  - blood, blood plasma or other blood products administered on an outpatient basis.
  - allergy sera and testing materials.
- Drugs used for the purpose of weight reduction, including the treatment of obesity.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Drugs labeled "Caution - Limited by Federal Law to Investigational Use" and experimental drugs.
- Drugs prescribed for uses other than the uses approved by the FDA under the Food, Drug and Cosmetic Law and regulations.
- Medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use.
- Diabetic supplies.
- Test agents and devices, except diabetic test strips.
- Injectable drugs, except insulin. The Plan does not cover:
  - injectable contraceptives (Depo-Provera)
  - injectable drugs used in the treatment of infertility.
- Oral and implantable contraceptive drugs and contraceptive devices.
- Prescription drugs purchased prior to the effective date, or after the termination date, of coverage under this Plan.
- Replacement of lost or stolen prescriptions.
- Drugs used to aid or enhance sexual performance, including but not limited to: Sildenafil citrate (e.g. Viagra), phentolamine, apomorphine and alprostadil in oral, injectable, and topical (including but not limited to gels, creams, ointments and patches) forms, and any prescription drug in oral, topical, or any other form that is in a similar or identical class, has a similar or

identical mode of action, or exhibits similar or identical outcomes, unless otherwise covered under this plan.

- Performance, athletic performance, or lifestyle-enhancement drugs and supplies.
- Smoking-cessation aids or drugs.
- Growth hormones.

## **Limitations**

The following limitations apply to the prescription drug coverage:

- A participating retail or mail order pharmacy may refuse to fill a prescription order or refill when, in the professional judgement of the pharmacist, the prescription should not be filled.
- Prescriptions may only be filled at a participating retail or mail order pharmacy, except in the event of emergency or urgent care. Aetna will not reimburse Plan participants for out-of-pocket prescription purchases from a non-participating pharmacy in non-emergency, non-urgent care situations.
- Plan participants must present their ID cards at the time each prescription is filled to verify coverage. If you do not present your ID card, your purchase may not be covered by the Plan, except in emergency and urgent care situations, and you may be required to pay the entire cost of the prescription.
- The conversion privilege does not apply to prescription drug coverage

## In Case of Emergency

### Guidelines

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

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

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

### Some examples of emergencies are:

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

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

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

## Follow-Up Care After Emergencies

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

## Urgent Care

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

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

### Some examples of urgent medical conditions are:

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

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

## What to Do Outside Your Aetna Service Area

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

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

## Plan Exclusions and Limitations

### Exclusions

The Plan does *not* pay benefits for *any* of the services, treatments or supplies described in this section, even if the either of the following is true:

- It is recommended or prescribed by a Physician
- It is the only available treatment for your condition

If you have any questions about plan exclusions, you should call Customer Service at the number indicated on your ID card.

**All exclusions and limitations in this section apply to all Plan members.**

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- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by Aetna.
- Blood, blood plasma or other blood derivatives or substitutes.
- Breast augmentation and otoplasties, including treatment of gynecomastia. Reduction mammoplasty is not covered unless medically necessary, as determined by Aetna.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including but not limited to mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:

- reconstructive surgery to correct the results of an injury.
  - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
  - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
  - Custodial care and rest cures.
  - Dental care and treatment, including (but not limited to):
    - care, filling, removal or replacement of teeth,
    - dental services related to the gums,
    - apicoectomy (dental root resection),
    - orthodontics,
    - root canal treatment,
    - soft tissue impactions,
    - alveolectomy,
    - augmentation and vestibuloplasty treatment of periodontal disease,
    - prosthetic restoration of dental implants, and
    - dental implants.
  - Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
  - Expenses that are the legal responsibility of Medicare or a third party payor.
  - Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.  
This exclusion will not apply to drugs:
    - that have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
    - that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
    - that Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.
 Refer to the “Glossary” for a definition of “experimental and investigational.”

- False teeth and/or dental implants.
- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids, eyeglasses, or contact lenses or the fitting thereof.
- Household equipment and or convenience items, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work.
- Implantable drugs
- Infertility services, except as described under *Your Benefits*. The Plan does *not* cover:
  - Purchase of donor sperm and any charges for the storage of sperm.
  - Purchase of donor eggs, and any charges associated with care of donor required for donor egg retrievals or transfers or gestational carriers.
  - Cryopreservation and storage of cryopreserved embryos.
  - All charges associated with a gestational carrier program (surrogate parenting) for the Plan participant or the gestational carrier.
  - Drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
  - Injectable infertility drugs.
  - The costs for home ovulation prediction kits.
  - Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.
  - Services for females with FSH levels greater than 19mIU/ml on day 3 of the menstrual cycle.
- Oral and implantable contraceptive drugs and devices, except when prescribed to treat certain medical conditions.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.

- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips.
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Private duty or special nursing care, unless pre-authorized by Aetna.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
  - obtaining or continuing employment,
  - obtaining or maintaining any license issued by a municipality, state or federal government,
  - securing insurance coverage,
  - travel, and
  - school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.
- Services or supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
  - Services that exceed any Plan limitations as to number of visits, etc.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.

- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:
  - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,
  - needles, syringes and other injectable aids except as described under Prescription Drugs.
  - drugs related to treatments not covered by the Plan, and
  - drugs related to the treatment of infertility, contraception, and performance-enhancing steroids.
- Specific non-standard allergy services and supplies, including (but not limited to):
  - skin titration (wrinkle method),
  - cytotoxicity testing (Bryan’s Test),
  - treatment of non-specific candida sensitivity, and
  - urine autoinjections.
- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury or congenital defects.
- Surgical operations, procedures or treatment of obesity.
- Therapy or rehabilitation, including (but not limited to):
  - primal therapy.
  - chelation therapy.
  - rolfing.
  - psychodrama.
  - megavitamin therapy.
  - purging.
  - bioenergetic therapy.
  - vision perception training.
  - carbon dioxide therapy.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant’s physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies, and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries, or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health treatment or medical treatment of the retarded individual as described under “Your Benefits.”
- Treatment of occupational injuries and occupational disease, including injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does. If you are covered under a Workers’ Compensation law or similar law, and submit proof that you are not covered for a particular disease or injury under such law, that disease or injury will be considered “non-occupational,” regardless of the cause.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
  - treatment performed by prosthesis placed directly on the teeth,
  - surgical and non-surgical medical and dental services, and
  - diagnostic or therapeutic services related to TMJ.
- Weight reduction programs and dietary supplements.
- Weight reduction surgery or procedures, including but not limited to gastric bypass surgery.

## **Limitations**

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

## Special Programs

### **National Medical Excellence Program®**

The National Medical Excellence Program offers access to carefully selected physicians and hospitals that specialize in the treatment of complex medical conditions such as tissue and organ transplants. The program has three components:

- National Transplantation Program, designed to help arrange care for solid organ and bone marrow transplants
- National Special Case Program, developed to coordinate arrangements for treatment of Plan participants with complex conditions at tertiary care facilities across the country when that care is not available within 100 miles of the Plan participant's home
- Out of Country Program, designed for Plan participants who need emergency inpatient medical care while temporarily traveling outside of the United States.

If you need a transplant or other specialized care that cannot be provided within the service area, the NME Program will coordinate covered services and will provide the following lodging and travel expenses if you must travel more than 100 miles:

- Transportation expenses you and a companion (if applicable) incur while traveling between your home and the Program facility. Travel expenses incurred by more than one companion are not covered.
- As the NME patient, your lodging expenses incurred while traveling between your home and the National Medical Excellence facility to receive covered services;
- The lodging expenses you incur for lodging away from home to receive covered outpatient services from a NME Program provider;
- The lodging expenses incurred by a companion traveling with you from your home to a National Medical Excellence provider so you can receive covered services; and
- Your companion's lodging expenses when their presence is required to enable you to receive services from a NME Program provider on either an inpatient or outpatient basis. Only the lodging expenses incurred by **one** companion are covered per night.

Benefits for travel and lodging expenses are subject to a maximum of \$10,000 per episode of care. Lodging expenses are subject to a \$50 per night maximum for each person.

**Travel and lodging expenses must be approved in advance by Aetna;** if you do not receive approval, the expenses are *not* covered.

You become eligible for coverage of travel and lodging expenses on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earlier to occur of:

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

Travel and lodging expenses do not include expenses that are covered under any other part of the Plan.

The Plan covers only those services, supplies and treatments that are considered necessary for your medical condition. Treatment that is considered experimental (as determined by Aetna) is *not* covered by the Plan. Refer to the *Glossary* for a definition of “experimental.”

## **Women’s Health Care**

The Plan focuses on the special needs of women through several programs that promote the health and well-being of female Plan participants throughout each distinct life stage.

### ***Direct Access Gynecology Program***

This program allows a female Plan participant to visit any participating gynecologist for one routine well-woman exam (including a Pap smear) per year, without a referral from her PCP. Women must be 18 years of age to be eligible for the exam. The Plan also covers additional visits for treatment of gynecological problems and follow-up care, without a PCP referral. Participating gynecologists may also refer a woman directly for appropriate gynecological services without the patient having to go back to her participating PCP.

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

### ***Maternity Management Program***

The Maternity Management Program is an Aetna program that coordinates your care when you are pregnant, and helps you prepare for delivery and beyond. This program provides:

- Assistance in accessing prenatal care.
- Case management by registered nurses, who will assist in arranging covered services, coordinate covered specialty care, review the program’s features and answer general pregnancy-related questions.
- Smoke-free Moms-to-be™, a personalized stop-smoking program designed specifically for pregnant women.
- Focused, educational information, “For Dad or Partner.”
- A comprehensive pregnancy handbook.

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

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

### ***Genetic Testing for Breast and Ovarian Cancers***

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

### ***Menopause Program***

Beginning at age 40, each female Plan participant (who has selected a primary care physician) receives educational information about menopause with her annual mammography reminder. This includes a take-at-home osteoporosis self-evaluation, which she can complete and discuss with her provider.

## **Cancer Screening Programs**

Because early detection is so important to successful treatment, Aetna has developed nationally acclaimed, state-of-the-art breast, colorectal and cervical cancer screening programs. These programs provide you and the members of your family with an effective means of earlier cancer detection.

### ***Breast Cancer Screening***

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

### ***Cervical***

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

### ***Colorectal***

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

## **Healthy Outlook Disease Management Program®**

The Healthy Outlook Program helps Plan participants manage conditions such as asthma, diabetes, heart failure and low back pain by providing resources that help keep them out of the hospital, develop healthier habits and improve their quality of life.

Participants in the Healthy Outlook Program can take advantage of disease-specific programs developed by Aetna to minimize or avoid complications through early detection and treatment.

## **Wellness Programs**

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, Aetna's Wellness Programs can help you follow a sensible nutrition plan, quit smoking and stay physically active. To obtain information on Wellness Programs, call the toll-free number on your ID card.

### ***Adolescent Immunization***

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

### ***Childhood Immunization Program***

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

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

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

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. The reminder

contains a list of immunizations recommended at 18 months.\* The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing the immunizations.

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

\*Source: Office of Prevention and Health Promotion, in cooperation with the agencies of Public Health Services, US Dept. of Health and Human Services, Center for Disease Control.

### ***Healthy Eating™ Program***

Aetna's *Healthy Eating* booklet is an easy-to-follow approach to overall better health through good nutrition. The information provides you and your family with tools you can use to develop a healthy eating plan that's realistic. Following a nutritious diet can help you:

- Reduce your risk of illness and disease
- Manage your weight
- Boost your ability to fight illness
- Increase your energy levels
- Look and feel your personal best
- Improve your performance

The *Healthy Eating* booklet outlines the benefits of a health diet and how to get started. It's geared toward helping you understand and use the Food Guide Pyramid, read the "Nutrition Facts" labels on most foods, lower the amount of fat you eat, and become more physically active. Sensible weight management is also addressed. The booklet is available to all Plan participants.

Call the Member Services number on your Aetna ID card to request the Healthy Eating booklet.

### ***Healthy Breathing® Program***

Quitting smoking is one of the biggest steps people can take to improve their health. Millions of people successfully quit smoking each year. That's why Aetna offers the Health Breathing Program, which provides access to the GlaxoSmithKline's committed Quitters® service. The program is available to Plan participants. The program is an 8 to 12 week smoking cessation program that uses nicotine replacement therapy and a personal quit plan to help smokers break their addiction to cigarettes.

Eligible Plan participants who call Member Services using the toll-free number on their Aetna ID cards can obtain a brochure that contains a \$5 coupon redeemable for the purchase of either a Nicorette® (the nicotine chewing gum) or NicoDerm® CQ® (the nicotine patch) Starter Kit\*. These products can help ease the craving for nicotine and improve the chances of quitting successfully. They are available without a doctor's prescription, although you should discuss use of these products with your physician.

Nicorette® and NicoDerm® CQ® are registered trademarks owned by and/or licensed to GlaxoSmithKline and are used under license.

### ***Informed Health® Line***

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

Informed Health® Line is available to eligible employees and their families virtually 24 hours per day, 365 days per year from anywhere in the U.S.

Backed by the Healthwise® Knowledgebase™ (a computerized database of over 1,900 of the most common health problems) and an array of other online and desk references, the nurses help you understand health issues, treatment options, review specific questions to ask your provider, provide research analyses of treatments and diagnostic procedures, and explain the risks and benefits of various options. The nurses encourage patient/provider interaction by coaching you to give a clear medical history and information to providers and to ask clarifying questions.

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

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

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

### ***Breast Cancer Case Management***

Aetna’s breast cancer case management program assists female Plan participants who have been diagnosed with breast cancer in making informed choices for their care. This special educational and support program includes:

- A dedicated breast cancer nurse case manager to answer your questions about coverage, assist with necessary claims authorizations, and facilitate access to treatment by participating specialists and primary care physicians and at participating facilities
- Educational materials
- Second opinions at participating facilities

### **Fitness Program**

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

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

- Discounts on certain home exercise equipment.

*\* For current club members, participation under this program may not be available at all clubs.*

*\*\*Not available at all clubs.*

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

## **Alternative Health Care Programs**

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

**Vitamin Advantage™** - You can save on over-the-counter vitamins, as well as nutritional supplements purchase through mail order, over the phone, by fax, or over the internet.

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

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

**To Find Out More** - Call the Member Services number on your ID card, or visit the Aetna website at [www.aetna.com/products/natural\\_alt\\_99.html](http://www.aetna.com/products/natural_alt_99.html) for a listing of participating providers, vendors and the latest additions to the product list.

*Natural Alternatives is not available in all states.*

## **Vision One® Discount Program**

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

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

*Vision One is a registered trademark of Cole Vision.*

## **Eligibility**

### **Who Is Eligible to Join the Plan**

You are eligible to enroll in the Plan if you are a full-time employee of The Bank of New York and you work or reside in the Plan's service area.

When you join the Plan, your spouse and your dependent children are also eligible to join. A dependent child must be unmarried and under the age of 19. Coverage will continue until the end of the year in which the child attains age 19. A child may be covered up to the end of the year in which the child attains age 25 if they are a full-time student. Proof of full-time student status is required each year.

You may enroll your eligible domestic partner in the Plan. Please contact The Bank of New York's Employee Benefit Services Department for information about eligibility, enrollment procedures, costs and tax considerations.

You may enroll your natural child, foster child, stepchild, legally adopted child, a child under court order, or a grandchild in your court-ordered custody.

No person may be covered as both an employee and a dependent under the Plan, and no person may be covered as a dependent of more than one employee.

#### ***If Your Child Is Adopted***

Coverage for your legally adopted child is effective on the date the child is placed with you for adoption if:

- The placement takes place on or after the effective date of your coverage (you must show proof of placement); and
- You request coverage for the child in writing within 31 days of the placement.

#### ***If Your Child Does Not Reside With You***

If your child does not live with you, but they live in another Aetna service area, they can choose a PCP in that service area. Your child's coverage under the Plan will then be the same as yours.

A child covered by the Plan who does not reside in an Aetna service area can choose a PCP in your network and return to your network service area for care.

In the event of an emergency that occurs outside of your service area, out-of-area dependents should obtain necessary care as described under "In Case of Emergency," then contact their PCP to coordinate follow-up care.

### ***If Your Child Is Handicapped***

Unmarried children of any age who are handicapped may also be covered. Your child is handicapped if:

- He or she is not able to earn his or her own living because of a mental or physical disability which started prior to the date he or she reached age 19 or age 25 if attending school full-time; and
- He or she depends chiefly on you for support and maintenance.

You must provide proof of your child's handicap no later than 31 days after the child's coverage would otherwise end.

Coverage for a handicapped child ends on the first to occur of the following:

- The child's handicap ceases;
- You fail to provide proof that the handicap continues;
- The child fails to have a required examination by an Aetna participating PCP; or
- The child's coverage as a dependent under the Plan ceases for any reason ***other than*** attainment of the maximum age for dependent coverage.

### ***Qualified Medical Child Support Order (QMCSO)***

A QMCSO is a court order requiring a parent to provide health care benefits to one or more children. Coverage under the Plan can be extended to a child who is covered by a QMCSO, if:

- The QMCSO is issued on or after the date your coverage becomes effective; and
- Your child meets the definition of an eligible dependent under the Plan; and
- You request coverage for the child within 31 days of the court order.

Coverage will be effective on the date of the court order.

## **Enrollment**

### ***New Employees***

When you are first eligible to enroll in the Plan, you will be given enrollment and benefit information, including an enrollment form. You must complete the enrollment form and return it to your Human Resources representative within 31 days of the date you become eligible if you wish to participate in the Plan. If you do not return the form within the 31-day period, The Bank of New York will assume that you have waived coverage, and you will not be allowed to participate in the Plan until the next open enrollment period, unless you have a change in status.

## ***Open Enrollment***

The annual open enrollment period is your opportunity to review your benefit needs for the upcoming year and to change your benefit elections, if necessary. Open enrollment is held each fall, and the elections you make will be in effect January 1 through December 31 of the following calendar year.

## **Change in Status**

You may change coverage any time during the year because of a change in your status. A change in status is:

- Your marriage, divorce, legal separation or annulment;
- The birth or adoption of a child;
- The death of your spouse or child;
- A change in the number of your dependents;
- A change in employment status for you, your spouse or your dependent; or
- The beginning or end of an unpaid leave of absence taken by you or your spouse.

Whenever you have a change in status, you must report the change by completing a change form, available from The Bank of New York's Employee Benefit Services department. The completed change form must be given to Employee Benefit Services within 31 days of the event. Otherwise, you must wait until the next The Bank of New York open enrollment period.

**Note:** Newborn children are automatically covered for 31 days after birth. To continue the coverage beyond 31 days, you must apply by submitting a change form to Employee Benefit Services within the 31-day period.

## **Coordination of Benefits**

If you have coverage under other group plans, the benefits from the other plans will be taken into account if you have a claim. This may mean a reduction in benefits under the Plan.

Benefits available through other group plans and/or no-fault automobile coverage will be coordinated with the Plan. "Other group plans" include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured; and
- "No-fault" and traditional fault auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law.

To find out if benefits under the Plan will be reduced, Aetna must first determine which plan pays benefits first. The determination of which plan pays first is made as follows:

1. The plan without a coordination of benefits (COB) provision determines its benefits before the plan that has such a provision.
2. The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent. If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows:
  - The plan that covers the person as a dependent of a working spouse will pay first;
  - Medicare will pay second; and
  - The plan that covers the person as a retired employee will pay third.
3. Except for children of divorced or separated parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first. When both parents' birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan doesn't have the parent birthday rule, the other plan's COB rule applies.
4. When the parents of a dependent child are divorced or separated:
  - If there is a court decree which states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in No. 3, immediately above, apply.
  - If a court decree gives financial responsibility for the child's medical, dental or other health care expenses to one of the parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent.
  - If there is no such court decree, the order of benefits will be determined as follows:
    - the plan of the natural parent with whom the child resides,
    - the plan of the stepparent with whom the child resides,
    - the plan of the natural parent with whom the child does not reside, or
    - the plan of the stepparent with whom the child does not reside.
5. If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.
6. The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.
7. If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

If it is determined that the other plan pays first, the benefits under the Plan will be reduced. Aetna will calculate this reduced amount as follows:

- The amount normally reimbursed for covered benefits under this Plan.

*Less*

- Benefits payable from your other plan(s).

If your other plan(s) provides benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

### **Right of Recovery (Subrogation and/or Reimbursement)**

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to all rights of recovery a covered Plan participant has against any party potentially responsible for making any payment to that Plan participant due to the Plan participant's injuries or illness, to the full extent of benefits provided or to be provided by the Plan. In addition, if a covered Plan participant receives any payment from any potentially responsible party as a result of an injury or illness, the Plan has the right to recover from, and be reimbursed by, the Plan participant for all amounts this Plan has paid and will pay as a result of that injury or illness, up to and including the full amount the Plan participant receives from all potentially responsible parties. A "covered Plan participant" includes, for the purposes of this provision, anyone on whose behalf the Plan pays or provides any benefit, including (but not limited to) the minor child or dependant of any Plan participant or person entitled to receive any benefits from the Plan.

As used throughout this provision, the term "responsible party" means any party possibly responsible for making any payment to a covered Plan participant due to that Plan participant's injuries or illness or any insurance coverage, including (but not limited to) uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, med-pay coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The covered Plan participant shall do nothing to prejudice the Plan's subrogation and reimbursement rights and shall, when requested, fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the covered Plan participant to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the covered Plan participant.

The covered Plan participant acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties and are to be paid to the Plan before any other claim for the Plan participant's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the covered Plan participant which is insufficient to make the Plan participant whole or to compensate the Plan participant in part or in whole for the damages

sustained. It is further agreed that the Plan is not required to participate in or pay attorney fees to the attorney hired by the Plan participant to pursue the covered person's damage claim.

The terms of this entire subrogation and reimbursement provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the covered Plan participant identifies the medical benefits the Plan provided. 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.

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the covered Plan participant and this Plan agree that Aetna shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

## **When Coverage Ends**

Your coverage will end if:

- You voluntarily terminate coverage;
- Your employment terminates;
- You are no longer eligible for coverage;
- You do not make the required contributions;
- You become covered under another health care plan offered by The Bank of New York; or
- The Plan is discontinued.

Coverage for your dependents will end if:

- Your coverage ends for any of the reasons listed above;
- You die;
- Your dependent is no longer eligible for coverage;
- Your payment for dependent coverage is not made when due; or
- Dependent coverage is no longer available under the Plan.

## ***Termination for Cause***

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

- **Untenable relationship:** After reasonable efforts, Aetna and/or the Plan's participating providers are unable to establish and maintain a satisfactory provider-patient relationship with you or a Plan participant of your family. You will be given 31 days advance written notice of the termination of coverage.
- **Failure to make copayments:** You or a member of your family fails to make any required copayment or any other payment that you are obligated to pay. You will be given 31 days advance written notice of the termination of coverage.

- **Refusal to provide COB information:** You or a member of your family refuses to cooperate and provide any facts necessary for Aetna to administer the Plan's COB provision. You will be given 31 days advance written notice of the termination of coverage.
- **Furnishing incorrect or incomplete information:** You or a member of your family willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in, or obtaining benefits from, the Plan. Termination will be effective immediately.
- **Fraud against the Plan:** This may include, but is not limited to, allowing a person who is not a participant of the Plan to use your Aetna member ID card. Termination will be effective immediately.
- **Misconduct:** You or a covered member of your family abuses the system, including (but not limited to) theft, damage to the property of a participating provider, or forgery of drug prescriptions. Termination will be effective immediately.

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

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

## Family and Medical Leave

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

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by The Bank of New York to be terminated; or
- The Plan is discontinued.

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

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

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is

terminated because of your gross misconduct, you will not be eligible for COBRA continued coverage.

## **COBRA Continuation of Coverage**

You and your dependents have the right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue medical coverage under certain circumstances (called “qualifying events”) when you would otherwise lose coverage. To do so, you must pay up to 102% of the full regular cost of coverage.

### ***Continuation of Coverage Following Termination of Employment or Loss of Eligibility***

You and your covered family members are eligible to continue coverage for up to 18 months if:

- You leave your employer for any reason other than gross misconduct; or
- You are no longer eligible because your working hours are reduced.

You may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue their own coverage.

If you or your dependent is disabled, as defined by the Social Security Administration, at the time of the qualifying event or becomes disabled within 60 days of the event, you may be entitled to an extra 11 months of coverage, for a total of 29 months. You must notify your Human Resources representative of the disability before the end of the original 18-month period to receive the extension, and you must pay up to 150% of the full cost of coverage for every month after the 18<sup>th</sup> month. Coverage may be continued for the disabled individual and for any family member for whom coverage is already being continued under COBRA, as well as for your newborn or newly adopted child who was added after the date COBRA continuation began. COBRA continuation of benefits will end on the first day of the month that begins more than 30 days after the final determination under Title II or XVI of the Social Security Act that the disabled individual is no longer disabled.

### ***Continuation of Coverage Due to Other Qualifying Events***

Your eligible dependents can continue coverage for up to 36 months if coverage would otherwise cease because:

- You die;
- You are divorced;
- You stop making contributions for a spouse from whom you are legally separated;
- You become entitled to Medicare; or
- A covered child is no longer eligible under the Plan.

If one of the above events occurs while you or a covered dependent have already continued coverage due to the termination of your employment or your loss of eligibility, your dependent

may extend coverage beyond the original 18-month continuation period, but for no more than a total of 36 months from the date coverage would originally have ended.

### ***Applying for COBRA Continuation***

Your Human Resources representative will give you information about how to continue COBRA coverage at the time you become eligible.

You must inform your employer of any status changes that would make your dependents eligible for COBRA coverage within 60 days of the later to occur of:

- The occurrence of the event; and
- The date coverage would terminate due to the event.

To ensure that there is no break in coverage, the election to continue coverage must be made within 60 days of:

- The date coverage would terminate due to the event; or
- The date your employer informs your dependents of their right to continue coverage;

... whichever happens later.

If you do not make your election within 60 days, you will lose your COBRA continuation rights.

### ***When COBRA Continuation Coverage Ends***

Continuation coverage will end on the earliest date that:

- The COBRA continuation period expires.
- You or your family members do not make the required contributions.
- You or your family members become covered under another group health plan, unless that plan contains a provision that restricts the payment of benefits for a pre-existing condition. Once the pre-existing condition clause of the new plan ceases to apply, your COBRA coverage will cease.
- You or your family members become enrolled in Medicare. (Coverage could continue for those individuals not eligible for Medicare for up to 36 months from the original qualifying event, provided those family members otherwise remain eligible.)
- Your employer terminates this health plan.

## **Conversion From Group to Individual Membership**

Most Plan participants who terminate employment or cease to be eligible for benefits may convert to individual membership without evidence of good health if their place of residence remains within the Aetna service area. If you have been continuously enrolled in the Plan for three months,

you and/or your eligible dependent may apply to Aetna for a conversion policy within 31 days after:

- Termination of employment.
- Loss of group membership.
- Loss of dependent status.
- Termination of any continuation coverage required under federal or state law.

The converted coverage will not provide the same benefits as the The Bank of New York HMO Plan. The rate you pay will be the premium charged for individual policies.

For necessary forms and information about the conversion plan, call the toll-free number on your ID card.

**Note:** Certain benefits cannot be converted.

## Rights and Responsibilities

### Your Rights and Responsibilities

#### As a Plan participant, you have a right to:

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

### **As a Plan participant, you have the responsibility to:**

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

### **Patient Self-Determination Act (Advance Directives)**

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

#### ***What Is an Advance Directive?***

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

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

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

### ***What Is a Living Will?***

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

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

### ***What Is a Durable Power of Attorney for Health Care?***

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

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

### ***Who Decides About My Treatment?***

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

### ***How Do I Know What I Want?***

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

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

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

- If you have a Durable Power of Attorney, give a copy of the original to your “agent” or “proxy.” Your agent or proxy is the person you choose to make your medical decisions when you are no longer able.

- Ask your PCP to make your Advance Directive part of your permanent medical record.
- Keep a second copy of your Advance Directive in a safe place where it can be found easily, if it is needed.
- Keep a small card in your purse or wallet that states that you have an Advance Directive and where it is located, and who your agent or proxy is, if you have named one.

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

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

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

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

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

***Do I Have to Execute an Advance Directive?***

No. It is entirely up to you.

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

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

***Can I Change My Mind After Writing an Advance Directive?***

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

***What Is the Plan's Policy Regarding Advance Directives?***

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

You are not required to execute an Advance Directive. **If you choose to complete an Advance Directive, it is your responsibility to provide a copy to your physician and to take a copy with**

**you when you check into a hospital or other health facility so that it can be kept with your medical records.**

***How Can I Get More Information About Advance Directives?***

Call the Member Services toll-free number on your ID card. Or, you can call Partnership for Caring at Choice in Dying, a community organization, at 1-800-989-9455.

**Member Services**

**Member Services Department**

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

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

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

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

## **Internet Access**

You can access Aetna on the World Wide Web at **www.aetna.com** to conduct business with the Member Services department electronically.

When you visit the Member Services site, you can:

- Find answers to common questions;
- Change your PCP;
- Order a new member ID card; or
- Contact the Member Services department with questions.

Please be sure to include your member ID number, Social Security number and e-mail address.

## **InteliHealth®**

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

## **Informed Health® Line**

Staying informed is one step you can take toward meeting the challenge to stay healthy. As a valued participant in a plan administered by Aetna, you have access to the Informed Health Line service - a 24-hour toll-free line that is your direct link to a team of experienced registered nurses. These nurses can provide information on a variety of health issues at any time, day or night. Informed Health Line nurses cannot diagnose, prescribe or give medical advice. Contact your PCP first with any questions or concerns regarding your health care needs.

*Informed Health Line is provided by Informed Health Inc., under contract with your health plan. Informed Health is a registered trademark of Aetna Life Insurance Company.*

## **Aetna Navigator™**

Aetna Navigator provides a single location for the health and medical issues that matter most to you.

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from IntelliHealth®. Access Aetna Navigator™ through the Aetna Internet website home page or directly via Log on to [www.aetnanavigator.com](http://www.aetnanavigator.com).

When you visit the website, you can see some of Aetna Navigator's distinct features:

- A wealth of health information from IntelliHealth, a premier provider of online consumer-based health, wellness and disease-specific information.
- Online customer service functions that allow you to change your primary care physician or primary care dentist, order ID cards and send e-mail inquiries to Member Services.
- Interactive "Cool Tools," including a medical dictionary, allergy and asthma quizzes, a pregnancy due-date calculator and a heart and breath odometer. To access "Cool Tools," look under "Health Tools."
- A preventive care planner that includes recommendations for screenings and immunizations.

Plan participants with certain Aetna plans may also create password-protected Web pages that are personalized to their health care interests. They have access to the features listed above as well as other options including:

- A personal "benefits snapshot" and claims summary.
- DocFind-A-Specialist, our enhanced online provider directory that helps Plan participants select a specialist based on personal needs and preferences.
- An online survey that allow you to receive customized information based on your personal health interests.

## **Claims Procedures**

A claim occurs whenever a Plan participant requests:

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

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

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

Adverse benefit determinations are decisions Aetna makes that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

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

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

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

	prior to the expiration of the approved treatment  Other claims - 15 calendar days
<b>Concurrent care claim reduction or termination:</b> a decision to reduce or terminate a course of treatment that was previously approved.	With enough advance notice to allow the Plan participant to appeal
<b>Post-service claim:</b> a claim for a benefit that is not a pre-service claim.	30 calendar days

### Extensions of Time Frames

The time periods described in the chart may be extended.

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

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

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

### Grievances and Appeals

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

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

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

#### Grievances

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

### Appeals of Adverse Benefit Determinations

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

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

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

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

Depending on the type of appeal, you and/or an authorized representative may attend the Level 2 appeal hearing and question the representative of Aetna and any other witnesses, and present your case. The hearing will be informal. You may bring your physician or other experts to testify. Aetna also has the right to present witnesses.

If the Level One and Level Two appeals uphold the original adverse benefit determination, you may have the right to pursue an external review of your claim. See “External Review” for more information.

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

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

	the adverse benefit determination.	making the adverse benefit determination.
<b>Concurrent care claim extension:</b> a request to extend a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim, depending on the circumstances.	Treated like an urgent care claim or a pre-service claim, depending on the circumstances.
<b>Post-service claim:</b> a claim for a benefit that is not a pre-service claim.	30 calendar days  Review provided by Plan personnel not involved in making the adverse benefit determination.	30 calendar days  Review provided by Plan personnel not involved in making the adverse benefit determination.

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

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

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

## External Review

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

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

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

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

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

- You have received notice of the denial of a claim by Aetna; and
- Your claim was denied because Aetna determined that the care was not medically necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds \$500; and
- You have exhausted the applicable Plan appeal process.

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

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

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

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

### ***Claim Fiduciary***

For the purpose of section 503 of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA), Aetna is fiduciary with complete authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its fiduciary responsibility, Aetna has discretionary authority to:

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

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

## **Subrogation**

If you or a covered family member receives benefits from this plan as the result of an illness or injury caused by another person, the Plan has the right to be reimbursed for those benefits from any settlement or payment you receive from the person who caused the illness or injury. This means the Plan may recover costs from all sources (including insurance coverage) potentially responsible for making any payment to you or your covered dependent as a result of an injury or illness, including:

- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Med-pay coverage;
- Workers' Compensation coverage;
- No-fault automobile coverage; or;
- Any first party insurance coverage.

## **What You Need to Know**

Here are some important points about the right of subrogation:

***The Plan has a lien on any payments you receive.***

The Plan automatically has a lien, to the extent of any benefits it has paid, on any payment you've received from a third party, his/her insurer or any other source. The lien is in the amount of benefits paid by Aetna under this Plan for treatment of the illness, injury or condition for which the other person is responsible.

***Your cooperation is required.***

You may not do anything to interfere or affect the Plan's subrogation rights.

You also must fully cooperate with the Plan's efforts to recover benefits it has paid. This includes providing all information requested by the Claims Administrator or its representatives. As part of this process, Aetna may ask you to complete and submit certain applications or other forms or statements. If you fail to provide this information, it will be considered a breach of contract and may result in the termination of your health benefits or the instigation of legal action against you.

***You must notify Aetna.***

If a lawsuit or any other claim is filed to recover damages due to injuries sustained by you or a covered family member, you must notify Aetna. This must be done within 30 days of the date the notice of the lawsuit or claim is given to a person, including an attorney.

***The Plan is paid first.***

The Plan's subrogation rights are a first priority claim against all potentially responsible person(s), and must be paid before any other claim for damages.

***The Plan is entitled to full reimbursement.***

The Plan is entitled to full reimbursement first from any payments made by any responsible person(s). This reimbursement must be made, even if the payment is not enough to compensate you or your covered family member in part or in whole for damages. The terms of this plan provision apply and the Plan is entitled to full recovery whether or not any liability for payment is admitted by any potentially responsible person(s), and whether or not the settlement or judgment you receive identifies the medical benefits provided by the Plan. The Plan may be reimbursed from ***any and all*** settlements and judgements, even those for pain and suffering or non-economic damages only.

***Aetna chooses the court for any legal action.***

Any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction Aetna selects. When you receive benefits under this Plan, you agree to this rule and waive whatever rights you have by reason of your present or future place of residence.

***The Plan is not responsible for your attorneys' fees.***

The Plan is not required to participate in or pay attorney fees to the attorney you hire to pursue your claim for damages.

***Interpreting this provision.***

If there is any question about the meaning or intent of this plan provision or any of its terms, the Plan will have the sole authority and discretion to resolve all disputes as to how this provision will be interpreted.

## Plan Information

### Your ERISA Rights

The Employee Retirement Income Security Act of 1974, known as ERISA, guarantees your rights as a Plan participant. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan Documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. 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 support order (QMCSO).
- Continue health care coverage for yourself, spouse and/or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and Beneficiaries.

No one, including your Employer 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.

If your claim for a 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 you 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, if it finds your claim is frivolous.

If you have any questions about your 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.

### General Information About the Plan

Employer/Plan Sponsor	The Bank of New York One Wall Street New York, NY 10286 212-495-1784
Employer Identification Number	13-2614959
Plan Name	The Medical Plan of The Bank of New York Company, Inc.
Plan Number	510
Plan Type	Welfare: Medical
Plan Year	The Plan Year runs from Jan. 1 to Dec. 31
Plan Administrator	The Bank of New York One Wall Street New York, NY 10286 212-495-1784
Type of Administration	The Plan is administered under a contract with Aetna Life Insurance Company.

Source of Contributions to the Plan	Employer funded.
Agent for Service of Legal Process	Officer in Charge – Benefits Department The Bank of New York Company, Inc. One Wall Street New York, NY 20286

## **Amendment or Termination of the Plan**

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

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

## **Plan Documents**

This plan description covers the major features of the HMO Plan administered by Aetna Life Insurance Company, effective January 1, 2004. The plan description has been designed to provide a clear and understandable summary of the Plan, and serves as the Summary Plan Description (SPD) required for plans subject to ERISA.

## **Federal Notices**

This section describes laws and plan provisions that apply to reproductive and women’s health issues.

## **The Newborns’ and Mothers’ Health Protection Act**

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

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

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

## **The Women's Health and Cancer Rights Act**

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

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

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

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

## Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Hospice care** - means a program of care that is:

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

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

**Infertility** – means:

For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.

For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

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

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

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

- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

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

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

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

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

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

- Psychosis;
- Affective disorders;
- Anxiety disorders;
- Personality disorders;
- Obsessive-compulsive disorders;
- Attention disorders with or without hyperactivity; and
- Other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether

or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

**NME patient** - means a person who:

- Requires any National Medical Excellence procedure or treatment covered by the Plan;
- Is approved by Aetna as an NME patient; and
- Agrees to have the procedure or treatment performed in a facility designated by Aetna as the most appropriate facility.

**Outpatient** - means:

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

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

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

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

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

**Plan participant** - means an employee or covered dependent.

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

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

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

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

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

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

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

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

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

*All benefits are subject to and governed by applicable contracts, policies and government regulations. The information herein is believed accurate as of the date of publication and is subject to change without notice.*

*The Bank of New York reserves the right to amend, modify or eliminate this Plan at any time, as to present employees, future employees and/or retirees, either generally or in individual cases, with or without advance notice.*



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