GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO: Chris Jennings

FAX NO.: 456-5557

FROM: Karen Counts

DATE: 4-9-99

PAGES INCLUDING THIS COVER SHEET: 6

COMMENTS: Hope this helps.

K

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April 9, 1999

Note to Chris Jennings

As promised, here is the information on standard coverage and rates in New Jersey, where both the small group and individual markets are tightly regulated and only standard coverage can be sold. Hope the print is not too small to read on a faxed copy.

Premiums for individual coverage in New Jersey are all over the map. This reflects some insurers' desire to "exit" the individual market in practice. (There's a financial penalty if they formally exit the market) About three-fourths of people who buy coverage in the individual market take the Blue Cross standard plan for $177.91/month (January 1999 rates).

For this amount, health coverage is comprehensive (with no lifetime maximum) and covered services (with no day/dollar limits) include: hospitalization, physician visits, emergency room care, diagnostic tests and X-ray, home health, immunizations and mammography, Rx drugs, and maternity care. Calendar year maximums are applied to preventive care ($500) and mental health/substance abuse ($5,000.)

By contrast, for example, one low risk pregnancy under the Aetna plan appears to be eligible for a total of $1300 in benefits as follows: $300 for 6 prenatal visits (@$50 per visit), $1,000 for 2-night hospital stay (@$500 per night), $0 for obstetrician delivery, anesthesiologist, attending pediatrician, lab tests or ultrasound, etc. In other words, looks like Aetna would pay less than 10 cents on the dollar.

Aetna's premiums for this coverage, while low, certainly are not 10 cents on the dollar compared to comprehensive coverage. The low option premium is about 20 percent of the cost of the New Jersey Blue Cross plan, while the high option premium is about 40 percent of the cost.

As for your other questions, here's our best take:

Does the Aetna Plan count as creditable insurance coverage under HIPAA?

No. HIPAA specifically excludes from the definition of insurance "...fixed dollar indemnity insurance (for example, $100/day)...[when] there is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor..." (CFR2590.732) The Aetna plan underwriting rules specifically state that AffordableChoice is not available to an employer that offers other plan options to eligible employees that would coordinate benefits with AffordableChoice.

In addition, AffordableChoice includes other features that HIPAA specifically prohibits in group health plans: a preexisting condition exclusion period with a 12 month look back (no more than 6 months is permitted in HIPAA) and no credit for prior coverage. (HIPAA requires credit.)

Therefore, employees who sign up for AffordableChoice appear to not be protected by HIPAA. (Note that States can apply more lax definitions of "insurance" and "creditable coverage.")

Is the Aetna Plan subject to state mandated benefit laws?

The answer to this will vary state by state. It is possible that AffordableChoice might not be legally marketed in at least some states unless it is modified to meet state benefit standards and mandates.

Is the Aetna Plan subject to Patient Bill of Rights Laws?

Since the plan does not appear to require use of a limited provider network, many of the key PBOR protections would not be needed. *However, AffordableChoice enrollees might not have meaningful rights to internal or external appeal* when the plan denies care as "experimental" or "not medically necessary" for two reasons:

1. AffordableChoice covers only services that are medically necessary "as determined by Aetna" and excludes coverage for services that are experimental or investigative, "as determined by Aetna. (See page 1 of General Exclusions) By asserting sole discretion for defining what's medically necessary or experimental, Aetna has rendered pointless any appeal to an external, impartial expert.

2. Some PBOR proposals deny access to external review for denials of claims below a significant threshold, such as $1000. It's hard to be eligible for a benefit of that amount under AffordableChoice.

New Jersey Individual Standard Indemnity Plans Summary

PROVISION	PLAN A/50	PLAN B	PLAN C	PLAN D
Coinsurance Cap				
Per Covered Person	$5,000	$3,000	$2,500	$2,000
Per Covered Family	$10,000	$6,000	$5,000	$4,000
Per Lifetime Maximum Benefit	unlimited	unlimited	unlimited	unlimited
Coinsurance: Carrier/Covered Person	50%/50%	60%/40%	70%/30%	80%/20% applies to all covered charges except as otherwise noted
Deductible	policyholder's option	policyholder's option	policyholder's option	policyholder's option
Per Covered Person	$1,000 or $2,500	$1,000 or $2,500	$1,000 or $2,500	$500 or $1,000
Per Covered Family	$2,000 or $5,000	$2,000 or $5,000	$2,000 or $5,000	$1,000 or $2,000
Emergency Room Copayment in addition to Deductible, Coinsurance, other Copayments	$50 waived if admitted within 24 hours	$50 waived if admitted within 24 hours	$50 waived if admitted within 24 hours	$50 waived if admitted within 24 hours
Hospital Confinement Copayment	not applicable	in addition to deductible	not applicable	not applicable
Per Day Per Covered Person	not applicable	$200	not applicable	not applicable
Per Confinement, Per Covered Person	not applicable	$1,000	not applicable	not applicable
Per Calendar Year, Per Covered Person	not applicable	$2,000	not applicable	not applicable
COVERED CHARGES				
Note: Unless stated otherwise, all charges subject to payment of deductible, copayment, if any, and coinsurance				
Ambulance	covered	covered	covered	covered
Ambulatory Surgical Center	covered	covered	covered	covered
Anesthetics, Services and Supplies	covered	covered	covered	covered
Birthing Center	covered	covered	covered	covered
Blood, Blood Products, Transfusions, Testing and Processing	covered	covered	covered	covered
Dental Care and Treatment	tumors, cysts, bony impacted teeth, injury to teeth or jaw	tumors, cysts, bony impacted teeth, injury to teeth or jaw	tumors, cysts, bony impacted teeth, injury to teeth or jaw	tumors, cysts bony impacted teeth, injury to teeth or jaw
Diagnostic X-Ray/Lab	covered	covered	covered	covered
Dialysis Center	covered	covered	covered	covered
Durable Medical Equipment Note: Carrier Pre-Approval Required	covered	covered	covered	covered
Fertility Services	not covered	not covered	not covered	not covered
Home Health Care Note: Carrier Pre-Approval Required	covered	covered	covered	covered
Hospice Care Note: Carrier Pre-Approval Required	palliative and supportive care	palliative and supportive care	palliative and supportive care	palliative and supportive care
Hospital	Inpatient, special care unit, and outpatient covered	Inpatient, special care unit, and outpatient covered	Inpatient, special care unit, and outpatient covered	Inpatient, special care unit, and outpatient covered
Immunizations and Lead Screening Note: Deductible waived	covered; preventive care benefit may be used	covered; preventive care benefit may be used	covered; preventive care benefit may be used	covered; preventive care benefit may be used
Mammography	covered; preventive care benefit may be used	covered; preventive care benefit may be used	covered; preventive care benefit may be used	covered; preventive care benefit may be used
Non-Prescription Supplies	limited	limited	limited	limited
[illegible]onal Counseling [illegible]e: Carrier Pre-Approval Required	covered	co	covered	covered

New Jersey Individual Health Coverage Program Board

SINGLE	Plan A/50		Plan B		Plan C				Plan D				HMO Plans				Rx	Rate
	$1000 Deduct	$2500 Deduct	$1000 Deduct	$2500 Deduct	$1000 Deduct	$1500* Deduct	$2250* Deduct	$2500 Deduct	$500 Deduct	$1000 Deduct	$1500* Deduct	$2250* Deduct	$10 Copay	$15 Copay	$20 Copay	$30 Copay	50% or $15	Guar.
Aetna Life Insurance Company	339.00	276.00	401.00	345.00	475.00	-	-	408.00	892.00	655.00	-	-	-	-	-	-	-	12 mos
Aetna US Healthcare Insurance Company	-	-	-	-	-	-	-	-	-	-	-	-	296.80	258.90	225.60	-	50%	12 mos
AmeriHealth HMO, Inc.	-	-	-	-	-	-	-	-	-	-	-	-	363.00	274.00	231.00	-	50%	none
Celtic Insurance Company	345.00	301.00	431.00	388.00	1,249.00	-	-	950.00	2,646.00	1,694.00	-	-	-	-	-	-	-	3 mos
CIGNA HealthCare	-	-	-	-	-	-	-	-	-	-	-	-	264.25	255.61	243.02	-	50%	12 mos
Connecticut General	318.00	264.00	336.00	292.00	394.00	-	-	338.00	781.00	461.00			-	-	-	-		12 mos
First Option Health Plan	-	-	-	-	-	-	-	-	-	-	-	-	352.61	344.69	335.02	-	50%	none
Fortis Insurance Company	262.00	216.00	473.00	398.00	653.00	-	-	555.00	2,068.00	842.00	-	-	-	-	-	-	-	3 mos
Fortis Insurance Company (PPO)	-	-	-	-	-	-	-	-	1,648.00	753.00	-	-	-	-	-	-	-	3 mos
Guardian	417.00	348.00	431.00	362.00	477.00	-	-	391.00	1,063.00	702.00	-	-	-	-	-	-	-	none
Guardian PPO North (except Hunterdon)**	-	-	345.00	289.00	514.00	-	-	496.00	1,061.00	758.00	-	-	-	-	-	-	-	none
Guardian PPO South (except Salem)**	-	-	334.00	280.00	497.00	-	-	481.00	1,028.00	734.00	-	-	-	-	-	-	-	none
Horizon Blue Cross/Blue Shield of NJ	177.91	153.05	194.22	165.48	272.49	196.59	186.30	168.40	541.60	377.57	271.49	257.13	-	-	-	-	-	12 mos
Horizon HealthCare of NJ HMO Blue	-	-	-	-	-	-	-	-	-	-	-	-	369.36	352.43	-	267.81	50%	12 mos
Horizon HealthCare of NJ HMO Blue Prime	-	-	-	-	-	-	-	-	-	-	-	-	265.93	253.75	-	-	50%	12 mos
Manhattan National Life Insurance Company	-	-	585.51	-	843.21	-	-	611.96	2,630.19	1,696.84	-	-	-	-	-	-	-	3 mos
Metropolitan Life Insurance Company	-	-	294.00	-	315.00	-	-	304.00	693.00	401.00	-	-	-	-	-	-	-	none
National Health Insurance Company	428.00	334.00	441.00	352.00	540.00	-	-	394.00	845.00	662.00	-	-	-	-	-	-	-	none
Oxford Health Insurance Company	299.07	180.51	416.38	233.24	530.27	-	-	307.10	842.39	612.04	-	-	-	-	-	-	-	12 mos
Oxford Health Insurance Company (PPO)	-	-	-		241.83	-	-	-	-	270.29	-	-	-	-		-	50%	12 mos
Oxford Health Plans	-	-	-	-	-	-	-	-	-	-	-	-	-	287.52	253.37	-	50%	12 mos
PFL Life Insurance Company	196.00	166.00	215.00	178.00	389.00	-	-	338.00	1,011.00	724.00	-	-	-	-	-	-		none
Prudential HealthCare - NJ	-	-	-	-	-	-	-	-	-	-	-	-	305.00	289.75	259.25	-	50%	12 mos
QualMed Plans for Health	-	-	-	-	-	-	-	-	-	-	-	-	-	357.48	345.41	-	$15	12 mos
Trustmark Insurance w/o optional ABMT	700.00	600.00	800.00	700.00	1,000.00	-	-	800.00	2,400.00	1,600.00	-	-	-	-	-	-	-	none
Trustmark Insurance w/optional ABMT	735.00	630.00	840.00	735.00	1,050.00	-	-	840.00	2,520.00	1,680.00	-	-	-	-	-	-	-	none
United Health Care Insurance Company	392.00	309.00	503.00	413.00	518.00	-	-	435.00	1,100.00	656.00	-	-	-	-	-	-	-	none
United Health Care Plan	-	-	-	-	-	-	-	-	-	-	-	-	-	329.02	-	251.70	50%	12 mos

The above rates are monthly rates. Each carrier listed has filed its rates with the IHC Board and certified that its rates conform with applicable laws and regulations.

The above rates are in effect for new business and renewals which occur during the month shown at the bottom of this page.

Contact the carriers or your agent for rates for the following months. FOR A BUYERS' GUIDE CALL 1-800-838-0935.

*High deductible plan may be purchased with a medical savings account (MSA).

**The PPO plan rates shown are listed according to the out-of-network benefit level. A PPO plan listed under Plan C, for example, means that the out-of-network coinsurance is based on Plan C (70%/30% coinsurance). Contact the carriers for details on the plan design for the available PPO products.

January 1999

Revised 1/6/99

Other Charges	surgical and non-surgical care, treatment, and preventive care as described above	surgical and non-surgical care, treatment, and preventive care as described above	surgical and non-surgical care, treatment, and preventive care as described above	surgical and non-surgical care, treatment, and preventive care as described above
Pre-Admission Testing	covered	covered	covered	covered
Pregnancy	covered	covered	covered	covered
Prescription Drugs	covered	covered	covered	covered
Preventive Care Note: Deductible and Coinsurance Waived	calendar year maximum benefit $500 per covered person in first year of life; $300 per other covered persons	calendar year maximum benefit $500 per covered person in first year of life; $300 per other covered persons	calendar year maximum benefit $500 per covered person in first year of life; $300 per other covered persons	calendar year maximum benefit $500 per covered person in first year of life; $300 per other covered persons
Private Duty Nursing	not covered except as provided under Home Health Care	not covered except as provided under Home Health Care	not covered except as provided under Home Health Care	not covered except as provided under Home Health Care
Prosthetic Devices Note: Carrier Pre-Approval Required	covered	covered	covered	covered
Rehabilitation Centers Note: Carrier Pre-Approval Required	covered	covered	covered	covered
Routine Foot Care	not covered except as otherwise noted	not covered except as otherwise noted	not covered except as otherwise noted	not covered except as otherwise noted
Second Opinion	covered	covered	covered	covered
Temporomandibular Joint (TMJ) Dysfunction	surgical, non-surgical, except orthodontia	surgical, non-surgical, except orthodontia	surgical, non-surgical except orthodontia	surgical, non-surgical, except orthodontia
Therapeutic Manipulation	30 visits per calendar year maximum	30 visits per calendar year maximum	30 visits per calendar year maximum	30 visits per calendar year maximum
Therapy Services:				
Chelation Therapy	covered	covered	covered	covered
Chemotherapy	covered	covered	covered	covered
Dialysis Treatment	covered	covered	covered	covered
Radiation Therapy	covered	covered	covered	covered
Respiration Therapy	covered	covered	covered	covered
Speech, Cognitive Rehabilitation, Occupational and Physical Therapy	limited to 30 visits for each type of therapy/calendar year	limited to 30 visits for each type of therapy/calendar year	limited to 30 visits for each type of therapy/calendar year	limited to 30 visits for each type of therapy/calendar year
Infusion Therapy Note: Carrier Pre-Approval Required	covered	covered	covered	covered
Transplant Benefits: At option of carrier, coverage for autologous bone marrow transplant may be included in the plans or may be made available as a rider	specified procedures only	specified procedures only	specified procedures only	specified procedures only
Wilms Tumor	covered	covered	covered	covered
Alcohol Abuse	covered	covered	covered	covered
Nicotine Dependence Treatment	covered only as part of preventive care benefit	covered only as part of preventive care benefit	covered only as part of preventive care benefit	covered only as part of preventive care benefit
Mental or Nervous Conditions and Substance Abuse	50%/50% Coinsurance	60%/40% Coinsurance	70%/30% Coinsurance	75%/25% Coinsurance
Maximum Benefit Per Calendar Year	$5,000	$5,000	$5,000	$5,000
Maximum Benefit Per Lifetime	$25,000	$25,000	$25,000	$25,000
Utilization/Concurrent Review	Included (1)	Included (1)	Included (1)	Included (1)
Hospital Admission	Included (1)	Included (1)	Included (1)	Included (1)
Surgery	Included (1)	Included (1)	Included (1)	Included (1)
Case Management	Included (1)	Included (1)	Included (1)	Included (1)
Centers of Excellence	available	available	available	available

(1) Included items are not benefits, they are administrative provisions.

Ætna

Facsimile

From:
Vanda B. McMurtry
Senior Vice President
Federal Government Relations
Tel: (860) 273-0721
Fax: (860) 273-4479

PLEASE DELIVER IMMEDIATELY

To:	**Chris Jennings**	**Date: 3/199**
Fax Number:	**(202) 456-5557**	**Pages transmitted: 12**

Message:

Per our conversation—the latest version.

Van

If you have a problem receiving this transmission, please call Nancy Thompson at (860) 273-0738

U.S. AFFORDABLE CHOICE (2/26/99 pricing)

PLAN	100% Par. ER Pay All			50% Par.		
	Single	Two Party	Family	Single	Two Party	Family
RED	$68	$124	$207	$87	$160	$269
R-240	$46	$84	$146	$59	$108	$190
WHITE	$53	$96	$164	$67	$124	$213
W-240	$45	$81	$142	$57	$105	$184
BLUE	$34	$64	$117	$44	$84	$152
B-240	$32	$59	$109	$41	$77	$142

All plans have a separate 6 visit ER benefit for charges made by the ER department of the hospital. We will not pay both a physician's benefit and an emergency room hospital benefit for the same date of service. No Life or AD&D benefits on the Blue Plan.

Prices include a 3% commission expense and 5% profit.

240 Plans are for NY. The IP benefit is $240/day. Other benefits are the same as the RED, WHITE, and BLUE plans.

NOTE - All pricing assumes 12/12 Full Postponement Pre-ex with NO credit for prior coverage.

STANDARD U.S. AFFORDABLECHOICE PLANS

Benefit Provision	Blue (Low)	White (Medium)	Red (High)
Hospital Indemnity Includes Hospice and SNF at the hospital rate Successive confinements for the same condition must be separated by 90 days to receive the higher benefit levels of day 1 through 10	• $500/D for first 3 days • $200/D for days 4-10 • $100/D for days 11-unlimited • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day Includes Maternity	• $750/D for first 3 days • $350/D for days 4-10 • $100/D for days 11-unlimited • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day Includes Maternity	• $1500/D for first 3 days • $500/D for days 4-10 • $200/D for days 11-unlimited • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day • Includes Maternity
Dr. Visits Includes physician's service in the office, home, emergency room, walk-in clinic. (Includes treatment for accidents after 72 hours)	$50 per visit-up to 6 visits per calendar year ($300). Includes routine care through age 6.	$50 per visit-up to 8 visits per calendar year ($400). Includes routine care through age 6.	$50 per visit-up to 10 visits per calendar year ($500). Includes routine care through age 6.
Diagnostic Xray/Lab (Excludes lab in MD office which is considered part of the Office visit charge)	Not covered	$50 per visit-up to 8 outpatient visits per calendar year. ($400)	$50 per visit-up to 10 outpatient visits per calendar year. ($500)
Emergency Illness OP hospital charges for treatment in the emergency room. Standard ER illness definition applies	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)
Accident Benefits within 72 hours. Includes: • Hospital ER • urgicenter, clinic or physician's office	$50 per visit up to 6 visits per calendar year ($300).	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300).
Additional Programs • Natural Alternatives • Vision One Discount Program • Prescription Discounts (Retail & Mail Order)* • Dental Discounts • Informed Health • InteliHealth *When are where available	All programs included	All programs included	All programs included
Life AD&D (Ee only)	Not included.	$10,000 Life & $10,000 AD&D	$10,000 Life & $10,000 AD&D

2/26/99 Edited

NEW YORK U.S. AFFORDABLECHOICE PLANS

Benefit Provision	Blue (Low)	White (Medium)	Red (High)
Hospital Indemnity Includes Hospice and SNF at the hospital rate	• $240/D unlimited maximum • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day • Includes Maternity	• $240/D unlimited maximum • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day • Includes Maternity	• $240/D unlimited maximum • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day • Includes Maternity
Dr. Visits Includes physician's service in the office, home, emergency room, walk-in clinic. (Includes treatment for accidents after 72 hours)	$50 per visit-up to 6 visits per calendar year ($300). Includes routine care through age 6.	$50 per visit-up to 8 visits per calendar year ($400). Includes routine care through age 6.	$50 per visit-up to 10 visits per calendar year ($500). Includes routine care through age 6.
Diagnostic Xray/Lab (Excludes lab in MD office which is considered part of the office visit charge)	Not covered	$50 per visit-up to 8 outpatient visits per calendar year ($400).	$50 per visit-up to 10 outpatient visits per calendar year ($500).
Emergency Illness OP hospital charges for treatment in the emergency room. Standard ER illness definition applies	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)
Accident Benefits within 72 hours. Includes: • Hospital ER or • urgicenter, clinic or physician's office	$50 per visit up to 6 visits per calendar year. ($300)	$50 per visit up to 6 visits per calendar year. ($300)	$50 per visit up to 6 visits per calendar year. ($300)
Additional Programs • Natural Alternatives • Vision One Discount Program • Prescription Discounts* (Retail & Mail Order). • Dental Discounts • Informed Health • InteliHealth * Pharmacy discounts are currently available for NY	All programs included	All programs included	All programs included
Life AD&D (Ee only)	Not included.	$10,000 Life & $10,000 AD&D	$10,000 Life & $10,000 AD&D

GENERAL EXCLUSIONS

General Exclusions

No benefit is paid for or in connection with the followings stays or visits or services:

- Those not necessary, as determined by Aetna, for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed; recommended; or approved, by the attending physician.
- Those that are not prescribed, recommended and approved by the person's attending physician.
- Those received outside the United States.
- Those for experimental or investigative procedures, as determined by Aetna.
- Those for services of a resident physician or intern rendered in that capacity.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for custodial care.
- Those for education, special education or job training, whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for stays in connection with plastic surgery; reconstructive surgery; cosmetic surgery; or other services and supplies which improve, alter or enhance appearance (whether or not for psychological or emotional reasons); except to the extent needed to:

  Improve the function of a part of the body that:

  is not a tooth or structure that supports the teeth;

  is malformed:

  as a result of a severe birth defect; this includes harelip or webbed fingers or toes;

  as a direct result of:

  disease; or

  surgery performed to treat a disease or injury.

  Repair an injury which occurs while the person is covered under this Plan. Surgery must be performed:

  in the calendar year of the accident which causes the injury; or

  in the next calendar year.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.

GENERAL EXCLUSIONS CONTINUED

- Those for a voluntary sterilization procedure or the reversal of a sterilization procedure.
- Those for routine health examinations.
- Those for manipulative treatment or other physical treatment of spinal subluxation.
- Those for surgery except for any stay, visit or X-ray or lab test related to surgery (including hospital stays or follow up care).
- Those resulting from an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.

Any exclusion above will not apply to the extent that:

- a benefit is specifically provided elsewhere in this Policy.

These excluded servicest be used when figuring benefits.

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

DEFINITIONS

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in the benefit section and also appears in the Definitions section, the definition in the benefit section will apply in lieu of the definition in the Definitions section.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

  professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and

  physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician or R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Creditable Coverage

A person's prior medical coverage as defined in HIPAA. Such coverage includes: coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employee's Health Benefit Plan (FEHBP); a public health plan, as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

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

Dependent

Your:

- wife or husband; and
- unmarried children who are under 19 years of age.
- unmarried children under age 25 who go to school on a regular basis and depend solely on you for support.

Any other unmarried child:

- who was covered under your Participating Employer's prior plan of insurance on the day before the effective date of your Participating Employer's plan;
- who is dependent upon you because of mental retardation or physical handicap; and
- for whom you give Aetna proof of such mental retardation or physical handicap within 31 days after the effective date of your Participating Employer's plan.

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren.
- Children for whom you have been appointed legal guardian, who are dependent upon you for support.
- Any other child you support who either lives with you in a parent-child relationship or whose parent is your child and is covered as a dependent under this Plan.

Effective Treatment of Alcoholism Or Drug Abuse

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

- has a follow-up therapy program directed by a physician on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

As to drug abuse:

Detoxification. This is care mainly to overcome the aftereffects of a specific episode of drinking.

As to alcoholism or drug abuse:

Maintenance care. This means providing an environment free of alcohol or drugs.

Hospice Facility

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

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

Hospital

This is a facility which meets all of these tests:

- It provides inpatient services for the care and treatment of injured and sick people.
- It provides room and board services and nursing services 24 hours a day.
- It has established facilities for diagnosis and major surgery.
- It is run as a **hospital** under the laws of the jurisdiction which it is located.

Hospital does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; or as a nursing or rest home. The term "**hospital**" includes an alcohol
and drug addiction treatment facility during any period in which it provides effective treatment of alcohol and drug addiction to the covered person.

Intensive Care Unit

This is a designated ward, unit, or area within a **hospital** for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such **hospital**.

Medically Necessary

A service or supply that is necessary and appropriate for the diagnosis or treatment of a sickness or injury based on generally accepted current medical practice. A service or supply will not be considered as **medically necessary** if:

- it is provided only as a convenience to the covered person or provider; or
- it is not the appropriate treatment for the covered person's diagnosis or symptoms; or
- it exceeds (in scope, duration, or intensity) that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment.

Mental Disorder

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

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

Non-Occupational Disease

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

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

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

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

Non-Occupational Injury

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

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Physician

This means a legally qualified physician, who has a M.D. or D.O. degree.

R.N.
This means a registered nurse.

Spinal Subluxation
Any condition caused by or related to:

- biomechanical; or
- nerve conduction;

disorders of the spine.

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

Affordable Choice

Underwriting Rules

1. Available to **Employer Groups** with 2 or more employees (including PEOs)

2. **Employee eligibility**—all regular full- and part-time employees under age 65 or a class of 10 or more regular employees under age 65 not eligible for other plans offered by the employer (example: part-time workers working 15 to 30 hours per week). Seasonal or temporary employees not eligible (however, employees of a Temporary Service may qualify as "regular" employees of the Service). For regular part-time employees, AUSHC will not require a minimum number of hours worked per week, but the employer may choose to impose a minimum (but not higher than 15 hours per week).

3. **Dependent eligibility**—standard; children covered to age 19 (25 if in school).

4. **Late applicants**—may enroll only at annual enrollment or after a 12 month waiting period, whichever is less

5. **Retirees**—not eligible

6. **Actively At Work and Dependent Non-Confinement Rules**—apply.

7. **Pre-existing conditions** –12/12 rule, full postponement, no credit for prior coverage.

8. **Participation**— 50% participation required. This requirement can be waived if the following conditions are met:

   (a) the employer offers Affordable Choice to eligible employees in addition to a choice of one or more health options;

   (b) the employee contribution for Affordable Choice is lower than that for any of the health options; and

   (c) at least 75% of employees, not participating in a spouse's plan, must participate in either Affordable Choice or one of the health options offered by the employer.

9. **Coordination of Benefits**—not available to an employer that offers other plan options to eligible employees that would coordinate benefits with Affordable Choice.

Changes in Employee Health Coverage By Small Businesses

Small businesses are key to job growth in the United States, accounting for more than three-quarters of job expansion in most years. Over 40% of all employees work in firms with fewer than 100 employees or are self-employed. Yet this source of economic opportunity and growth is also the weakest link in America's employer-based health insurance system. The problems of the uninsured are closely tied to the availability and cost of health insurance in the small employer sector—where one out of every four workers is uninsured.

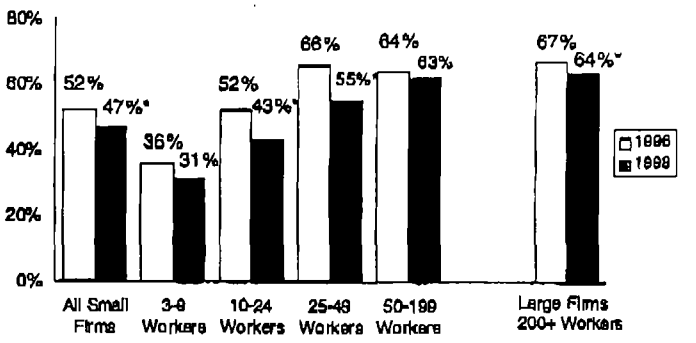
As part of the Kaiser Family Foundation's efforts to monitor changes in America's uninsured, it commissioned researchers at KPMG Peat Marwick to conduct national surveys of small businesses' health benefits in 1996 and 1998, as well as a new report prepared by Jon Gabel and associates, entitled Health Benefits of Small Employers in 1998. Key findings about the health benefits offered by small employers (firms with less than 200 employees) are summarized here, including changes in health premiums, cost-sharing requirements, eligibility for health benefits, and shifts in the types of plans small companies now offer.

Decreasing Health Coverage

During a period of robust economic growth between 1996 and 1998 the percentage of small business employees with coverage through their employer decreased from 52% to 47%. Decreases occurred across most sizes of firms, including large businesses. The erosion of coverage was most severe among firms with 25-49 workers, where 55% of all workers were covered by their own employers' plan in 1998, down from 66% in 1996 (Fig. 1)

Figure 1

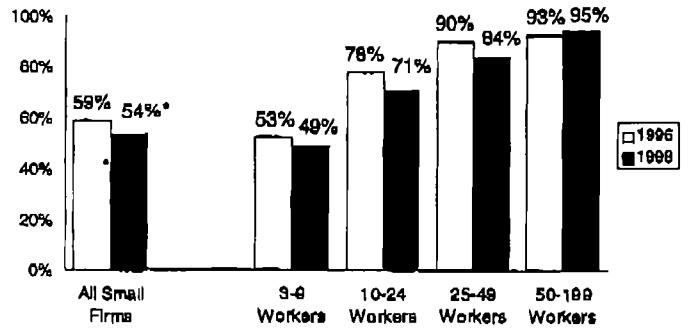
Percentage of Employees Covered by Own Employers' Health Plan, 1996-1998, by Firm Size



*Changes between 1996 and 1998 are statistically different ($p < .05$)

Figure 2

Percentage of Small Firms Offering Health Benefits, 1996-1998, by Firm Size



Note: Data for large firms are not available; however, almost all large firms offer health benefits
*Changes between 1996 and 1998 are statistically different ($p < .05$)

The decline in coverage is likely due to fewer small firms offering health benefits in 1998 than had in 1996—59% down to 54% (Fig. 2). Small business employees are as willing to participate in health plans as employees in larger firms. This is true across all sizes of small employers, despite the fact that premium contributions are greater in smaller firms and employees are earning less than workers in large firms. Health coverage may also be decreasing in part because employers are tightening the eligibility rules for coverage. Job-based health benefits in 1998 were less accessible to part-time workers in small businesses than in 1996 and the waiting period before an employee can enroll in the company's health plan increased.

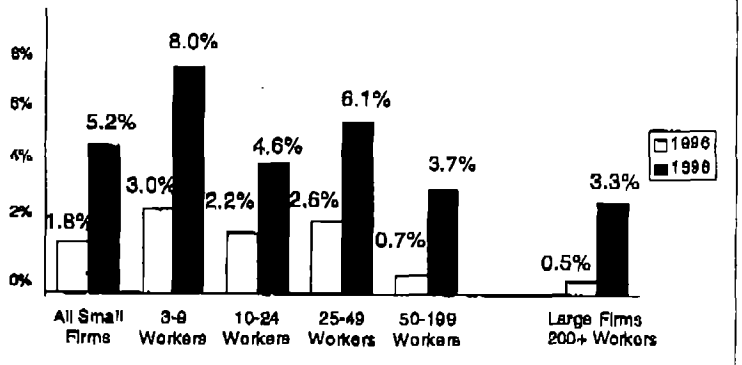
Increasing Health Insurance Costs

Cost to the Employer

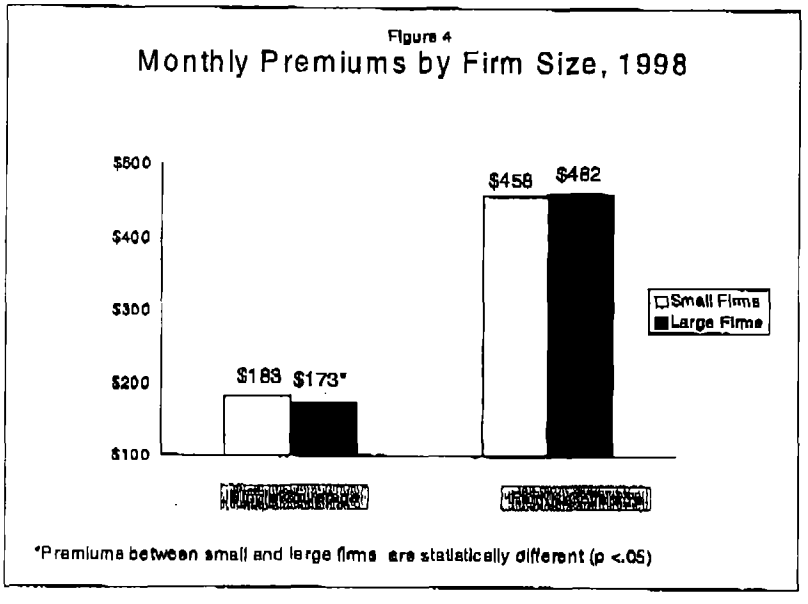
Premiums for small employers increased 5.2% overall between 1997 and 1998 (Fig. 3). The smallest employers (3-9 workers) experienced the greatest premium increase of 8%. While modest by historic standards, the 1998 premium increase substantially exceeded the rate of 1.8% for small businesses in 1996. Small employers (<200 workers) have typically experienced higher annual increases in their premiums than larger employers (200+ workers) employers by one to two percentage points, which continued to hold true in 1998.

Figure 3

Percentage Increase in Family Premiums, 1996 and 1998, by Firm Size



*Changes between 1996 and 1998 are statistically different for all firm sizes ($p < .05$)



The monthly cost of premiums in 1998 was about the same for small and large employers. Premiums for single coverage cost $183 for small firms and $173 for large firms on average (Fig. 4). Costs for family coverage were almost identical at about $460. An important exception is the substantially higher premiums paid by the smallest businesses (3-9 workers), where for example, monthly family coverage cost $520. While large businesses experienced increases in premiums for family coverage but not for their single coverage, small businesses experienced significant increases in both between 1996 and 1998.

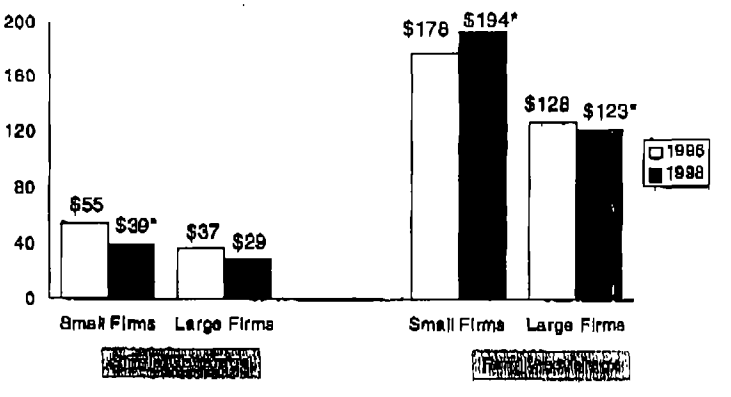
Increasing Health Insurance Costs

Costs to the Employee

Even though premiums are similar for small and large companies, employees in small firms pay a much larger share of the health premium than do employees of large firms. Family coverage for workers in small businesses was $194/month in 1998 compared to $123/month for large firms' employees. Cost-sharing for single coverage was also higher for employees of small businesses (Fig. 5).

Figure 5

Change in Monthly Employee Contributions 1996-1998, by Firm Size



*Changes between 1996 and 1998 are statistically different ($p < .05$)

Employee contributions for single coverage—in terms of absolute dollars—decreased among small businesses between 1996 and 1998, despite the fact that premiums increased for small employers. Contributions for family coverage however, did increase. It seems that small employers, in making trade-offs between the types of plans they offer and keeping employee contributions affordable, have decreased cost-sharing for single coverage of their own workers, but have not extended that to their workers' dependents.

Besides paying premiums, employees also shoulder the additional costs for deductibles. Workers in small firms pay more out-of-pocket here also. For example, their average preferred provider organization (PPO) single coverage deductible was $246 last year compared to $163 for workers in large firms. Employees of the smallest businesses (3-9 workers) paid the highest average deductibles, the most expensive being family conventional coverage at $948 in 1998.

In effect, health insurance offered to workers in small businesses is far less of a value. They contribute substantially more for premiums and also pay higher deductibles—both without the benefit of being able to choose among different types of health plans.

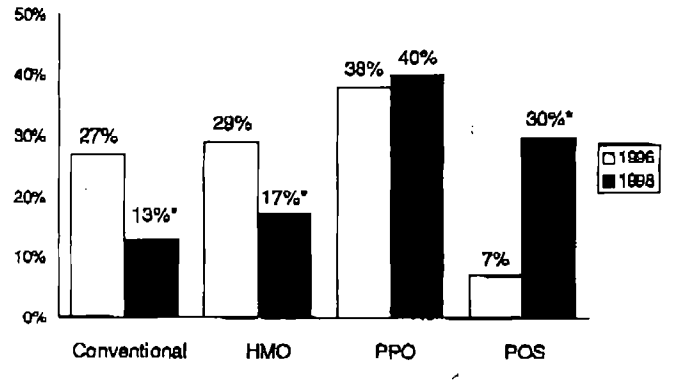
Increasing Health Insurance Costs

Shifting Away from HMOs

To temper premium increases, small employers have moved in recent years from more expensive conventional plans to less expensive managed care plans. However, between 1996 to 1998, small firms not only dropped conventional coverage, but they also dropped HMO coverage—perhaps in an effort to better balance premiums and choice in health providers. This pattern was also true for large businesses. Because HMOs do not require deductible amounts to be paid before the insurance covers some or all of the health services, they are the least expensive type of health plan from the employee's perspective.

Figure 6

Market Share of Health Plans Among Small Firms, 1996-1998



*Changes between 1996 and 1998 are statistically different ($p < .05$)

Firms dropping conventional coverage tend to move to PPOs, while employers dropping HMO coverage opt for point-of-service (POS) coverage. In fact, the largest shift in market share between 1996 and 1998 occurred in the percent of workers in small business who are covered by a POS plan—30% in 1998 compared to only 7% in 1996 (Fig. 6).

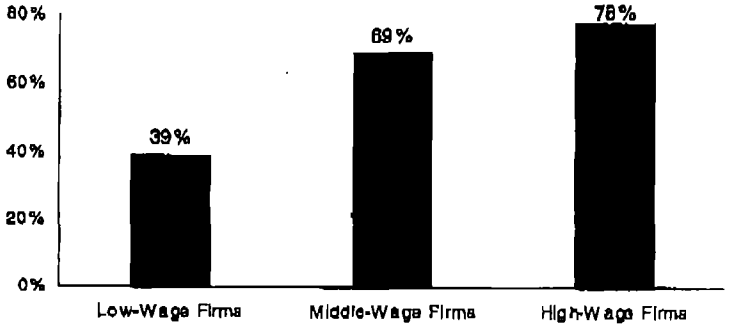
It's important to bear in mind that over 90% of small business employees who are offered health benefits have no choice in the type of health plan; only one is offered. Consequently, when small companies switch from an HMO plan to a POS plan, often to expand choice in health providers, employees will have to pay more. Even when HMO and POS premiums are the same, employees are now also responsible for the annual deductible when they incur medical expenses—and POS deductibles can be even higher than conventional plans' deductibles when using non-network providers.

Double Jeopardy for Workers:
Small businesses and Low Wages

Whether or not a firm offers health insurance coverage is a function not only of its size, but also its wage structure. Small businesses with many low-wage employees are far less likely to offer coverage than small firms with mostly higher-wage workers (Fig. 7). Among small businesses in 1998, "low-wage" companies (where 35% or more of the workforce earns less than $20,000/year) were half as likely to offer health benefits as "high-wage" companies (where 10% or less of the workforce earns less than $20,000).

Figure 7

Percentage of Small Firms Offering Health Coverage, by Wage Structure, 1998

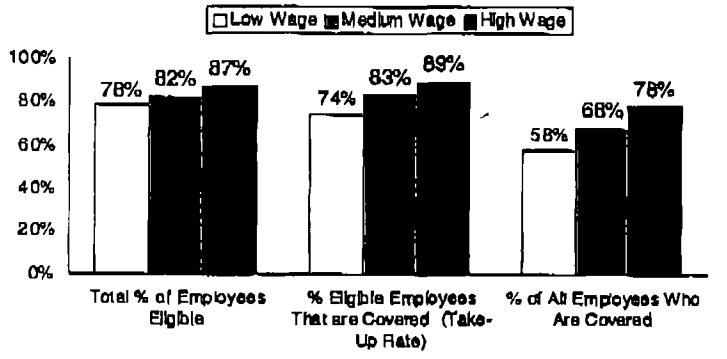


Note:
Low-wage firms—35% or more of workforce earn less than $20,000/year
Medium-wage firms—between 10.01 - 34.99% of workforce earn less than $20,000/year
High-wage firms—10% or less of workforce earn less than $20,000/year

Source: Gabel, J., for the Kaiser Commission on Medicaid and the Uninsured

Figure 8

Eligibility, Participation, and Coverage in Small Firms with Health Benefits by Wage Structure, 1998



Source: Gabel, J., for the Kaiser Commission on Medicaid and the Uninsured

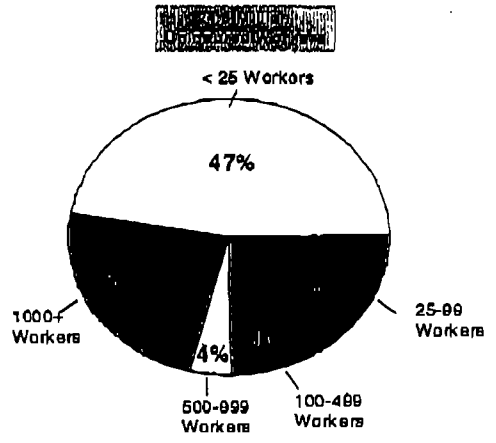
When health benefits are offered, take-up rates (the proportion of workers who choose to participate) in low-wage firms are remarkably high at 74% (Fig. 8). Almost 90% of workers in high-wage firms chose to participate in their own company's health plan in 1998. Low-wage firms require their employees to bear a somewhat greater share of the premium than high-wage firms, which may partially account for the differences in take-up rates. In addition, fewer employees are even eligible for benefits in low-wage firms. The result is that among small firms that offer health benefits, only 58% of low-wage companies' employees have health benefits through their job compared to 78% of employees in high-wage companies.

Uninsured Workers Disturbing Trends

The proportion of Americans insured through job-based coverage decreased significantly between 1987 and 1993, but has stayed relatively stable since then. These findings suggest the trend may begin to turn downward again.

Twenty five million workers—more than one in six workers in the United States was uninsured in 1997. Over 60% of uninsured workers are employed by businesses with fewer than 100 employees (fig. 9). More than three-quarters of the uninsured working in small companies are full-time employees. Most of these full-time workers are working for businesses that do not offer health benefits at all. In companies where benefits are offered some of the uninsured are new employees waiting to become eligible, some are part-time or temporary employees and will never be eligible, and others are choosing not to participate. More than two-thirds of uninsured workers make less than $20,000 a year, which makes buying individual health insurance coverage—and even paying part of an employer's plan—increasingly difficult.

Figure 9
Percentage of Uninsured Workers by Firm Size, 1997



Source: Kaiser Commission on Medicaid and the Uninsured

In the past decade nearly every state has enacted some form of health insurance reform to expand access to health plans for small businesses. Separating the impact of these laws from premium changes that occurred over the same period is difficult. Whether or not these laws have actually effected workers health coverage is not clear, at best they may have slowed the downward trend.

The changes in small business' health coverage are worrisome. Offer rates are declining and eligibility requirements are tightening even in these times of relatively lower premium growth (compared to double-digit premium inflation earlier in the decade). Should substantial inflation in health insurance premiums reoccur, the willingness of small employers to offer health benefits is likely to suffer further and even more workers may lose their health insurance.

Liberty Plans from Aetna U.S. Healthcare™ (Standard Policy Options)

Benefit Provision	Option 1	Option 2	Option 3
Hospital Indemnity Includes Hospice and SNF at the hospital indemnity rate Successive confinements for the same condition must be separated by 90 days to receive the higher benefit levels of day 1 through 10	• $500/D for first 3 days • $200/D for days 4-10 • $100/D for days 11-unlimited • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day Includes Maternity	• $750/D for first 3 days • $350/D for days 4-10 • $100/D for days 11-unlimited • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day Includes Maternity	• $1500/D for first 3 days • $500/D for days 4-10 • $200/D for days 11-unlimited • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day • Includes Maternity
Dr. Visits Includes physician's service in the office, home, emergency room, walk-in clinic. (Includes treatment for accidents after 72 hours)	$50 per visit-up to 6 visits per calendar year ($300). Includes routine care through age 6.	$50 per visit-up to 8 visits per calendar year ($400). Includes routine care through age 6.	$50 per visit-up to 10 visits per calendar year ($500). Includes routine care through age 6.
Diagnostic Xray/Lab (Excludes lab in MD office which is considered part of the Office visit charge)	Not covered	$50 per visit-up to 8 outpatient visits per calendar year ($400)	$50 per visit-up to 10 outpatient visits per calendar year ($500)
Emergency Illness OP hospital charges for treatment in the emergency room. Standard ER illness definition applies	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)
Accident Benefits within 72 hours. Includes: • Hospital ER • urgicenter, clinic or physician's office	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)
Additional Programs • Natural Alternatives • Vision One Discount Program • Prescription Discounts (Retail & Mail Order)* • Dental Discounts • Informed Health • InteliHealth *When are where available	All programs included	All programs included	All programs included
Life AD&D (Ee only)	Not included	$10,000 Life & $10,000 AD&D	$10,000 Life & $10,000 AD&D

Liberty Plans from Aetna U.S. Healthcare™ (New York State Policy Options)

Benefit Provision	Option 1	Option 2	Option 3
Hospital Indemnity Includes Hospice and SNF at the hospital indemnity rate	• $240/D unlimited maximum • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day • Includes Maternity	• $240/D unlimited maximum • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day • Includes Maternity	• $240/D unlimited maximum • $50/D Inpatient MH up to 180 days per confinement (600 days lifetime max) • 30 Day Alc/Drug -$50 per day • Includes Maternity
Dr. Visits Includes physician's service in the office, home, emergency room, walk-in clinic. (Includes treatment for accidents after 72 hours)	$50 per visit-up to 6 visits per calendar year ($300). Includes routine care through age 6.	$50 per visit-up to 8 visits per calendar year ($400). Includes routine care through age 6.	$50 per visit-up to 10 visits per calendar year ($500). Includes routine care through age 6.
Diagnostic Xray/Lab (Excludes lab in MD office which is considered part of the office visit charge)	Not covered	$50 per visit-up to 8 outpatient visits per calendar year ($400)	$50 per visit-up to 10 outpatient visits per calendar year ($500)
Emergency Illness OP hospital charges for treatment in the emergency room. Standard ER illness definition applies	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)
Accident Benefits within 72 hours. Includes: • Hospital ER or • urgicenter, clinic or physician's office	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)	$50 per visit up to 6 visits per calendar year ($300)
Additional Programs • Natural Alternatives • Vision One Discount Program • Prescription Discounts* (Retail & Mail Order). • Dental Discounts • Informed Health • InteliHealth * Pharmacy discounts are currently available for NY	All programs included	All programs included	All programs included
Life AD&D (Ee only)	Not included	$10,000 Life & $10,000 AD&D	$10,000 Life & $10,000 AD&D

General Exclusions

No benefit is paid for or in connection with the following stays or visits or services:

- Those not necessary, as determined by Aetna, for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed; recommended; or approved, by the attending physician.
- Those that are not prescribed, recommended and approved by the person's attending physician.
- Those received outside the United States.
- Those for experimental or investigative procedures, as determined by Aetna.
- Those for services of a resident physician or intern rendered in that capacity.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for custodial care.
- Those for education, special education or job training, whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for stays in connection with plastic surgery; reconstructive surgery; cosmetic surgery; or other services and supplies which improve, alter or enhance appearance (whether or not for psychological or emotional reasons); except to the extent needed to:

  Improve the function of a part of the body that:

  is not a tooth or structure that supports the teeth;

  is malformed:

  as a result of a severe birth defect; this includes harelip or webbed fingers or toes;

  as a direct result of:

  disease; or

  surgery performed to treat a disease or injury.

  Repair an injury which occurs while the person is covered under this Policy. Surgery must be performed:

  in the calendar year of the accident which causes the injury; or

  in the next calendar year.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.

GENERAL EXCLUSIONS CONTINUED

- Those for a voluntary sterilization procedure or the reversal of a sterilization procedure.
- Those for routine health examinations.
- Those for manipulative treatment or other physical treatment of **spinal subluxation.**
- Those for surgery except for any stay, visit or X-ray or lab test related to surgery (including hospital stays or follow up care).
- Those resulting from an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.

Any exclusion above will not apply to the extent that:

- a benefit is specifically provided elsewhere in this Policy.

These excluded services will not be used when figuring benefits.

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

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in the benefit section and also appears in the Definitions section, the definition in the benefit section will apply in lieu of the definition in the Definitions section.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

  professional nursing care by a R.N., or by a L.P.N. directed by a full-time R.N.; and

  physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

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

Dependent

Your:

- wife or husband; and
- unmarried children who are under 19 years of age.
- unmarried children under age 25 who go to school on a regular basis and depend solely on you for support.

Any other unmarried child:

- who was covered under your Participating Employer's prior plan of insurance on the day before the effective date of your Participating Employer's plan;
- who is dependent upon you because of mental retardation or physical handicap; and
- for whom you give Aetna proof of such mental retardation or physical handicap within 31 days after the effective date of your Participating Employer's plan.

~~Your children include:~~

- Your biological children.
- Your adopted children.
- Your stepchildren.
- Children for whom you have been appointed legal guardian, who are dependent upon you for support.
- Any other child you support who either lives with you in a parent-child relationship or whose parent is your child and is covered as a dependent under this Policy.

Effective Treatment of Alcoholism Or Drug Abuse

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

- has a follow-up therapy program directed by a physician on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

As to drug abuse:

Detoxification. This is care mainly to overcome the aftereffects of a specific episode of drinking.

As to alcoholism or drug abuse:

Maintenance care. This means providing an environment free of alcohol or drugs.

Hospice Facility

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

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

Hospital

This is a facility which meets all of these tests:

- It provides inpatient services for the care and treatment of injured and sick people.
- It provides room and board services and nursing services 24 hours a day.
- It has established facilities for diagnosis and major surgery.
- It is run as a **hospital** under the laws of the jurisdiction which it is located.

Hospital does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; or as a nursing or rest home. The term "**hospital**" includes an alcohol
and drug addiction treatment facility during any period in which it provides effective treatment of alcohol and drug addiction to the covered person.

Intensive Care Unit

This is a designated ward, unit, or area within a **hospital** for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such **hospital.**

Medically Necessary

A service or supply that is necessary and appropriate for the diagnosis or treatment of a sickness or injury based on generally accepted current medical practice. A service or supply will not be considered as **medically necessary** if:

- it is provided only as a convenience to the covered person or provider; or
- it is not the appropriate treatment for the covered person's diagnosis or symptoms; or
- it exceeds (in scope, duration, or intensity) that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment.

Mental Disorder

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

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

Non-Occupational Disease

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

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

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

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

Non-Occupational Injury

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

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Physician

This means a legally qualified physician, who has a M.D. or D.O. degree.

R.N.
This means a registered nurse.

Spinal Subluxation
Any condition caused by or related to:

- biomechanical; or
- nerve conduction;

disorders of the spine.

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

Liberty Plans from Aetna U.S. Healthcare™ UNDERWRITING RULES

1. Available to **Employer Groups** with 2 or more employees (including PEOs).

2. **Employee eligibility**—all regular full- and part-time employees under age 65 or a class of 10 or more regular employees under age 65 not eligible for other plans offered by the employer (example: part-time workers working 15 to 30 hours per week). Seasonal or temporary employees not eligible (however, employees of a Temporary Service may qualify as "regular" employees of the Service). For regular part-time employees, AUSHC will not require a minimum number of hours worked per week, but the employer may choose to impose a minimum (but not higher than 15 hours per week).

3. **Dependent eligibility**—standard; children covered to age 19 (25 if in school).

4. **Late applicants**—may enroll only at annual enrollment or after a 12 month waiting period, whichever is less.

5. **Retirees**—not eligible.

6. **Actively At Work and Dependent Non-Confinement Rules**—apply.

7. **Pre-existing conditions** –12/12 rule, full postponement, no credit for prior coverage.

8. **Participation**— 50% participation required. This requirement can be waived if the following conditions are met:

   (a) the employer offers AffordableChoice to eligible employees in addition to a choice of one or more health options;

   (b) the employee contribution for AffordableChoice is lower than that for any of the health options; and

   (c) at least 75% of employees, not participating in a spouse's plan, must participate in either AffordableChoice or one of the health options offered by the employer.

9. **Coordination of Benefits**—not available to an employer that offers other plan options to eligible employees that would coordinate benefits with AffordableChoice.

Liberty Plans from Aetna U.S. Healthcare™

(Use for 100% Enrollment only)

	Single	Two Party	Family
Option 1	$34	$64	$117
I-240 (NYS)	$32	$59	$109
Option 2	$53	$96	$164
II-240 (NYS)	$45	$81	$142
Option 3	$68	$124	$207
III-240 (NYS)	$46	$84	$146

Pricing is based on 100% enrollment and employer pay all.

All plans have a separate 6 visit ER benefit for charges made by the ER department of the hospital. We will not pay both a physician's benefit and an emergency room hospital benefit for the same date of service.

No Life or AD&D benefits are included in Option 1.

1, 2, and 3 240 represents the pricing for NYS policies. The in-patient benefit is $240/day; all other benefits are the same as the standard policies.

All pricing assumes 12/12 full postponement pre-existing condition rule with no credit for prior coverage.

3/18/99 Edited

100% Enrollment