

The attached files were developed and intended for use as a complete enrollment package; by distributing or posting the attached materials, you agree that the components may not be modified, omitted or used independently of one another. Your distribution and/or posting also memorializes your agreement that Aetna Inc. is not responsible for any miscommunication resulting from the separation of these materials.

# Aetna Affordable Health Choices<sup>SM</sup>

## Option I

AmeriCorps is pleased to offer health insurance underwritten by Aetna.

This limited accident and sickness insurance plan includes Medical coverage.

### Enclosed Materials (Your enrollment kit includes:)

- Temporary Member Identification (bottom of this letter) – Use this until you receive your permanent ID. This Temporary Identification is valid on the first day you becomes active in the AmeriCorps program, provided you do not waive coverage.
- Plan Brochure – Describes the specific benefits associated with your plan.
- Important Disclosure Information – Provides information on the rules associated with your plan.
- Member Reference Guide – Provides facts about your plan and a claim form.

If you are missing any of the contents of this kit, please see your AmeriCorps administrator or call Customer Service at **1-800-788-6557**.

### Key Terms

Deductible: the amount you pay annually for covered services before your plan starts paying.

Member Coinsurance: your portion of the cost of covered services after the deductible has been met.

Inpatient: services that require a minimum of 24 hours in the hospital; all other services are considered 'outpatient.'

*Si necesita ayuda en español, por favor llame al Centro del Servicio al Cliente al **1-800-788-6557** de lunes a viernes de 8:00 a.m. a 8:00 p.m. horario del Este.*

Cut out your Temporary Member Identification along the dotted line.

 MEDICAL AmeriCorps Grantee Option I	 An Aetna Company AETNA AFFORDABLE HEALTH CHOICES <sup>SM</sup>
EMPLOYEE NAME: _____ AND COVERED DEPENDENTS	
FOR MEMBER SERVICES CALL 1-888-772-9682	
PAYOR NUMBER 57604 0039	



Medical Insurance Plan is underwritten by Aetna Life Insurance Company and administered by Strategic Resource Company (SRC). Material is subject to change.

Policy forms issued in Oklahoma include: GR-9 and GR-29.



HEALTH CARE PROVIDER: The person listed on the front of this card has been enrolled under a limited major medical indemnity plan sponsored by the program listed on the front of this card. Covered members are entitled to benefits under the applicable plan, subject to exclusions and limitations. This card does not guarantee coverage. For verification of coverage, filing a claim or for questions other than the discount programs, contact us at the number printed on the front of this card or mail us at the address below.

INSURED: Physicians, hospitals, and other health care providers are independent contractors and are neither agents nor employees of Aetna Life Insurance Company.

EMERGENCY URGENT CARE: Call your local emergency hotline (ex.911) or go to the nearest emergency facility. For VISION ONE call 1-800-793-8616. For LASIK call 1-800-422-6600. For CONTACTS DIRECT call 1-800-391-5367.

Strategic Resource Company  
P.O. Box 23759  
Columbia, SC 29224-3759

**Notice to Members Concerning Health Care Services:** Your share of the payment for health care services may be based on the agreement between your health plan and your provider. Under certain circumstances, this agreement may allow your provider to bill you for amounts up to the provider's regular billed charges.

# Aetna Affordable Health Choices<sup>SM</sup>

## Plan Brochure

### **AmeriCorps Option I**

Enroll Today!

Questions? Call SRC toll free at 1-800-788-6557

Monday-Friday, 8 a.m. to 8 p.m. ET

**Guaranteed  
acceptance**

**Easy to use**

**See the doctor  
you choose**

Underwritten by Aetna Life Insurance Company.  
Administered by Strategic Resource Company (SRC).

B: NP12.4.ED-004 AMERICORPS (08/06)

We want you to know<sup>®</sup>



## Medical

A Limited Major Medical Insurance Plan.

The table on the right gives you a quick overview of the Medical Coverage.

- Use any licensed provider for covered expenses or any certified hospital.
- No precertification or approval is required.
- After you pay a \$100 deductible each coverage year, the plan will pay 80% of the recognized charges incurred for covered medical expenses until your \$1,000 annual out-of-pocket maximum is reached. Once your out-of-pocket maximum has been met, the plan will pay 100% of the recognized charges incurred for covered medical expenses up to a lifetime maximum benefit of \$50,000 per cause.
- Chiropractic services are included under spinal manipulation.
- Maternity is a covered expense.
- Prescription drugs are covered.

Exclusions and limitations apply. Refer to the Exclusions and Limitations section for details.

### Additional Benefit

- Aetna's Vision One® discount program, a nationwide network of vision care providers, offers you and your family glasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories at a discounted price. Plus, you can receive discounts on eye exams and LASIK eye surgery.

## BENEFIT

### Medical Expense Benefit

Annual deductible <sup>1</sup>	\$100
Percentage of eligible expenses paid by plan <sup>2</sup> (until annual out-of-pocket maximum is met)	80%
Annual out-of-pocket maximum (includes deductible) <sup>1</sup>	\$1,000
Percentage paid by plan after out-of-pocket maximum is met <sup>2</sup>	100%
Per cause maximum lifetime benefit <sup>3</sup>	\$50,000
Pre-existing conditions maximum benefit <sup>4</sup>	\$1,000
Prescription drugs <sup>5,6</sup>	50%
Pregnancy <sup>5</sup>	Covered

Other covered expenses<sup>5</sup> include fees for diagnosis & treatment by a doctor, surgeon, registered nurse, professional anesthetist, or radiologist; hospital charges; laboratory, diagnostic, and x-ray examinations; rental or purchase (whichever is less) of durable medical equipment; emergency professional ambulance service to the nearest hospital; elective termination of pregnancy; and serious mental & nervous disorders (schizophrenia, bipolar disorders, major depressive disorders, schizo-affective disorders, obsessive-compulsive disorders, panic disorders, eating disorders including anorexia nervosa and bulimia nervosa, and delusional disorders).

### Benefit Limits

Hospital benefits	
■ Daily room & board maximum <sup>7</sup>	\$600
■ Daily intensive care facility maximum <sup>7</sup>	\$1,200
■ Other hospital services (inpatient or outpatient) <sup>1</sup>	\$2,000
Substance abuse treatment <sup>8</sup>	
■ Maximum number of outpatient visits <sup>1</sup>	60
■ Maximum benefit per outpatient visit	\$35
■ Inpatient maximum <sup>1</sup>	\$10,000
Specified therapies (including acupuncture, physical therapy, and spinal manipulation) <sup>9</sup>	
■ Outpatient maximum <sup>1,10</sup>	\$1,000
■ Inpatient maximum <sup>1,10</sup>	\$10,000
Maximum benefit for injury due to motor vehicle accident <sup>1,10</sup>	\$10,000
Maximum benefit for injury due to organized sports injury <sup>1,10</sup>	\$5,000
Injury to sound, natural teeth, maximum benefit per tooth <sup>1,10</sup>	\$250
Maximum benefit for emergency professional ambulance service <sup>1</sup>	\$250

### Footnotes

1. Per coverage year.
2. Where benefit is expressed as a percentage, the recognized charge(s) will be the basis of payment.
3. You first have to meet your annual out-of-pocket maximum.
4. Benefits for pre-existing conditions are limited to the amount shown when incurred during the first 12 months of coverage. Full coverage for pre-existing conditions will be provided after 12 consecutive months of coverage, subject to the limitations of the plan.
5. Coinsurance, deductible, medical benefit maximums, and benefit limits apply.
6. Prescription drug benefit pays 50% until out-of-pocket maximum has been satisfied, then pays 100%, subject to the maximum lifetime benefit of the plan.
7. Plan will pay the maximum or actual hospital charges, whichever is less (room & board based on a semi-private room).
8. Maximum of one occurrence, inpatient or outpatient, per lifetime.
9. Covered only if immediately following covered surgery or hospital confinement.
10. Per cause or occurrence.

## More Questions?

Call SRC toll free at  
**1-800-788-6557**

**Monday through  
Friday, 8 a.m. to  
8 p.m. Eastern Time**

## Questions & Answers

### **Who is eligible?**

An active member of an AmeriCorps program may be eligible for coverage under this special health insurance plan. Coverage can begin immediately, unless you are covered by another health care plan. There is no family or dependent coverage available under this plan.

If you are covered under another plan (other than Medicaid or Medicare), you are not eligible for this benefit. If your coverage under another plan terminates, you can request to be covered under this plan. To decline coverage, you must complete a Waiver Form.

### **When does coverage begin?**

Your coverage is effective on the first day you become active in the AmeriCorps program, provided you are eligible and do not waive coverage. There is no waiting period.

### **If I leave the AmeriCorps program, can I continue my coverage?**

Yes. This plan has a special provision that allows the insured to continue coverage under the Plan after your service with your AmeriCorps Program has ended, as long as certain requirements are met and the program itself has not terminated.

### **What do I need to take with me when I visit a doctor?**

You should always carry your Member Identification and a claim form with you when you receive treatment.

### **What if a provider refuses to provide treatment unless I pay first?**

If the provider is requiring that you pay in advance because he/she is unsure of the coverage, the provider should contact SRC at 1-888-772-9682 to verify coverage and to receive a summary of benefits. If you, the member, need to contact SRC, please call 1-800-788-6557.

### **Do I have to complete a claim form for every claim?**

If you file your own claim, you must complete and submit a claim form for every itemized bill. But if your provider submits the claim, you do not need to complete a claim form. You can obtain a claim form by:

- Contacting the AmeriCorps Program Director
- Calling Claims Customer Service at 1-800-788-6557
- Writing to:  
SRC, an Aetna Company  
Attn: AmeriCorps Claims  
PO Box 23907  
Columbia, SC 29224-3907

# Exclusions and Limitations

**This is a summary list. Coverages, features, limitations and exclusions may vary by state. This is not a contract. Only the insurance policy can provide the actual terms, coverages, amounts, conditions, limitations and exclusions. Except to the extent coverage for such benefit is specifically provided in your Booklet Summary of Coverage and/or Certificate, coverage is not provided for the following charges:**

## Medical Pre-existing Condition Limitation:

A "pre-existing condition" is an injury or disease for which a person received treatment or services; or took prescribed drugs or medicines during the 180 days right before the person's effective date of coverage (or, if the Plan requires you to serve a probationary period, the 180 days right before the first day of the probationary period).

During the first 365 days of a person's current period of coverage, benefits paid for Eligible Medical Expenses incurred for the treatment of a pre-existing condition will not exceed \$1,000; unless the person has been covered for 180 continuous days and has received no care, treatment, or advice for the condition or has not taken prescribed drugs or medicines for the condition.

If a person had creditable coverage and such coverage terminated within 63 days prior to the date he or she enrolled (or was enrolled) in this Plan, then any limitation as to a pre-existing condition will be reduced by the number of days of prior creditable coverage. Also, if a person enrolls (or is enrolled) in this Plan immediately after any applicable probationary period has been served, and that person had creditable coverage which terminated within 63 days prior to the first day of such probationary period, then any limitation as to a pre-existing condition will be reduced by the number of days of prior creditable coverage. As used above: "creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. The pre-existing condition limitation above does not apply to newborn or adopted children, or to any pregnancy.

## Medical Exclusions:

- Services and supplies not necessary, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved;
- Service or supply rendered by someone who is related to a covered person by blood (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the covered persons household.
- Injury arising out of or in the course of employment; or which is compensable under any Workers' Compensation or Occupational Disease Act or Law;
- Care, treatment, services or supplies that are not prescribed, recommended, or approved by the person's attending physician or dentist;
- Experimental or investigational services, drugs or supplies except to the extent required by law;
- Cosmetic or reconstructive surgery: This does not apply to reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or because of congenital disease or anomaly of a covered person; or reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy;
- Dental care and treatment, except that required by injury and rendered within 6 months of the injury;
- Educational testing, or training related to learning disabilities or developmental delays;
- Services of a resident physician or intern rendered in that capacity;
- Charges made only because there is insurance or a person is not legally obligated to pay;
- Custodial care;
- Any expense incurred before the effective date of the policy or after the date the policy terminates;
- Eye surgery mainly to correct refractive errors;
- Education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment;
- Therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis;
- Any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy;
- Performance, or lifestyle enhancement drugs or supplies;
- Artificial insemination, in vitro fertilization, or embryo transfer or any related procedures except where required by law to be covered;
- Routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet-Certificate;
- Marriage, family, child, career, social adjustment, pastoral, or financial counseling;
- Speech therapy, except to restore speech to a person who has lost existing speech function as the result of a disease or injury;
- Inpatient or outpatient treatment of mental disorders; except serious mental illness;
- Private duty nursing;
- An injury sustained while the covered person was legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the injury occurred;
- An injury sustained while the covered person was voluntarily using any drug, narcotic or controlled substance unless as prescribed by a physician;

- Charges made by a hospital or treatment facility owned or run by the U.S. government unless a charge is made for such services in the absence of insurance;
- Charges made to treat an illness or injury sustained while flying as a pilot or crew member of any aircraft or travel or flight. This includes boarding or alighting in any vehicle or device while being used for any test or experimental purposes or while being operated by; for; or under; the direction of any military authority other than the Military Airlift Command of the United States or similar air transport service of any other country;
- Charges made by a hospital that does not unconditionally require payment (this does not apply to charges billed by Veterans Administration Hospitals);
- Charges made for outpatient services and supplies that are not deemed to be physician office visits; emergency room visits; diagnostic and surgical services; or prescription drugs and medicines;
- Voluntary sterilization procedure or the reversal of a sterilization procedure;
- Weight control services including: surgical procedures, medical treatments, weight control/loss programs; food supplements; or exercise programs;
- Charges furnished, paid for, or for which benefits are provided or required under any law of a government;
- Charges in excess of the recognized charge, based on the 80th percentile of the Medicode Medical Data Research Tables.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna arranges for the provision of health care services. However, Aetna itself is not a provider of health care services, and therefore, cannot guarantee any results or outcomes. Consult the plan documents (e.g., Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area and by plan design. Health insurance plans contain exclusions and some benefits are subject to limitations or visit maximums. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed. While this material is believed to be accurate as of the print date, it is subject to change.

# Important Disclosure Information

## For Indemnity Plans

### Plan of Benefits

Your plan of benefits will be determined by your plan sponsor and underwritten by the Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, Connecticut, 06156. The benefits and main points of the Group Policy for persons covered under your plan of benefits will be set forth in the Description of Coverage Booklet which will be provided to you at a later date.

### Cost Sharing

You are responsible for any copayments, coinsurance and deductibles for covered services. These obligations are paid directly to the provider or facility at the time the service is rendered. Copayment, coinsurance and deductible amounts are listed in your benefits summary and plan documents.

### Claims Payment and Use of Claims Software

Aetna determines the usual, customary and reasonable fee for a provider by referring to commercially available data reflecting the customary amount paid to most providers for a given service in that geographic area or by accessing other contractual arrangements. If such data is not commercially available, our determination may be based upon our own data or other sources. Aetna may also use computer software and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. You may be responsible for any charges Aetna determines are not covered under your plan.

### Medically Necessary

**"Medically necessary"** means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

- Clinically appropriate in accordance with **generally accepted standards of medical practice** in term of type frequency, extent, site and duration,
- Considered effective in accordance with **generally accepted standards of medical practice** for the illness, injury or disease; and

- Not primarily for your convenience, or for the physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

### **"Generally accepted standards of medical practice"**

means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. In the absence of such credible scientific evidence, the Plan's determinations of whether a service or supply meets "generally accepted standards of medical practice" shall be consistent with physician specialty society recommendations and otherwise shall be based on the views of physicians practicing in relevant clinical areas and any other relevant factors.

### **Clinical Policy Bulletins ("CPBs")**

Aetna's CPBs describe Aetna's policy determinations of whether certain services or supplies are medically necessary, based upon a review of currently available clinical information. Clinical determinations in connection with individual coverage decisions are made on a case-by-case basis consistent with applicable policies.

Aetna's CPBs do not constitute medical advice. Treating providers are solely responsible for your medical advice and treatment. You should discuss any CPB related to their coverage or condition with their treating provider.

While Aetna's CPBs are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. You and your provider will need to consult your benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

CPBs are regularly updated and are therefore subject to change. Aetna's CPBs are available online at [www.aetna.com](http://www.aetna.com).

## **Complaints, Appeals and External Review**

### **Filing a Complaint or Appeal**

Aetna is committed to addressing your coverage issues, complaints and problems. If you have a coverage issue or other problem, call Member Services at the toll-free number on your ID card. If Member Services is unable to resolve your issue to your satisfaction, it will be forwarded to the appropriate department for handling.

If you are dissatisfied with the outcome of your initial contact, you may file an appeal. If you are not satisfied after filing a formal appeal, you may request a second level appeal of the decision. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state law. Refer to your plan documents for further details regarding your plan's appeal procedure.

### **External Review**

Aetna established an external review process to give eligible you the opportunity of requesting an objective and timely independent review of certain coverage denials. Once the applicable appeal process has been exhausted, eligible members may request an external review of the decision if the coverage denial, for which the member would be financially responsible, involves more than \$500\*, and is based on lack of medical necessity or on the experimental or investigational nature of the proposed service or treatment. Standards may vary by state, if a state-mandated external review process exists and applies to your plan.

An independent review organization (IRO) will assign the case to a physician reviewer with appropriate expertise in the area in question. After all necessary information is submitted, an external review generally will be decided within 30 calendar days of the request.

Expedited reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. Once the review is complete, the plan will abide by the decision of the external reviewer. The cost for the review will be borne by Aetna (except where state law requires members to pay a filing fee as part of the state-mandated program).

Certain states mandate external review of additional benefit or service issues; some may require a filing fee. In addition, certain states mandate the use of their own external review process for medical necessity and experimental/ investigational coverage decisions. These state mandates may not apply to self-funded plans. For further details regarding your plan's appeal process and the availability of an external review process, call the Member Services toll-free number on your ID card where you may obtain an external review request form. You also may call your state insurance or health department or consult their website for additional information regarding state-mandated external review procedures.

## **Confidentiality and Privacy Notices**

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify you.

When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third-party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

\* Does not apply in some states, including North Carolina.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and antifraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that many individuals do not want to receive unsolicited marketing materials unrelated to their health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent.

To obtain a hard copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please write to Aetna's Legal Support Services Department at 151 Farmington Avenue, W121, Hartford, CT 06156. You can also visit our Internet site at **[www.aetna.com](http://www.aetna.com)**. You can link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

# Other Disclosures

## **Louisiana**

Aetna will not in any way use the results of genetic testing to discriminate against applicants or enrollees.

## **Michigan**

### **Intractable Pain Coverage**

Aetna provides benefits for the evaluation and treatment of intractable pain when it is determined to be medically necessary and otherwise eligible by Aetna. Intractable pain means "a pain state in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted practice of allopathic or osteopathic medicine, no relief of the cause of the pain or cure of the cause of the pain is possible or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending physician and by one or more other physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain."

To obtain this and further information on the health plan, you may call Member Services at 1-888-772-9682.

# Health Insurance Portability and Accountability Act Member Notice\*

**The following information is provided to inform the member of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by the member in accordance with Federal law.**

## **Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact your benefits administrator.

## **Request for Certificate of Creditable Coverage**

Members of insured plan sponsors and members of self insured plan sponsors who have contracted with us to provide Certificates of Prior Health Coverage have the option to request a certificate. This applies to terminated members, and it applies to members who are currently active but who would like a certificate to verify their status. Terminated members can request a certificate for up to 24 months following the date of their termination. Active member can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number on the back of your ID card.

\* While this Member Notice is believed to be accurate as of the publication date, it is subject to change. Please contact the Member Services department if you have any questions.

# Notice to Members

While this information is believed to be accurate as of the print date, it is subject to change.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna arranges for the provision of health care services. However, Aetna itself is not a provider of health care services and therefore, cannot guarantee any results or outcomes. Consult the plan documents [Booklet-certificate, Booklet, Group Policy] to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area and by plan design. These plans contain exclusions and some benefits are subject to limitations or visit maximums. With the exception of Aetna Rx Home Delivery<sup>®</sup>, all physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC. Is a subsidiary of Aetna Inc.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The company that underwrites benefits coverage is Aetna Life Insurance Company. Aetna offers part-time and hourly workers access to affordable health and preventive care services through Strategic Resource Company (SRC), an Aetna company.

**If you need this material translated into another language, please call Member Services at 1-888-772-9682.  
Si usted necesita este documento en otro idioma, por favor llame a Servicios al Miembro al 1-888-772-9682.**

# Aetna Affordable Health Choices<sup>SM</sup>

## Member Reference Guide

### Facts About The Plan

---

Group Name: .....AmeriCorps

Eligible Members: .....All active full-time members of an AmeriCorps Program, provided the member is not covered by another health care plan (other than Medicaid or Medicare).

Eligibility: .....Immediate.

Your Coverage Begins: .....Immediately, provided you are eligible.

Plan Name: .....Aetna Affordable Health Choices<sup>SM</sup>

Underwriter of the coverage(s) issued under the plan:

Insurance plans: .....Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, Connecticut 06156

Aetna Affiliate: .....Strategic Resource Company (SRC)  
221 Dawson Road / PO Box 23759  
Columbia, SC 29224-3759

Insured members: Benefits/Enrollment: .....(800) 788-6557  
Claims Inquiries: .....(800) 788-6557

Providers: General: .....(800) 788-6557  
Verification of Benefits: .....(888) 772-9682

Provider(s) of the discount program(s) within the plan:

Eyewear Discount Card: .....Vision One®

Exam and Eyewear: .....(800) 793-8616 (Weekdays 9 a.m. - 9 p.m., Saturday 9 a.m. - 5 p.m. ET)

LASIK Customer Service: .....(800) 422-6600 (Weekdays 8 a.m. - 9 p.m., Saturday 9 a.m. - 6 p.m. ET)

Contacts Direct<sup>TM</sup>: .....(800) 391-5367 .....[www.aetna.com/docfind/custom/aahc](http://www.aetna.com/docfind/custom/aahc)

## Extra-Territorial Information

---

Some states require that certain benefits or provisions be provided to their residents regardless of where the group insurance policy that covers those residents is issued. If you are a resident of one of those states, your state's requirements will apply to you in place of the benefits or provisions in your policy when those requirements provide a greater benefit or right than described in your policy.

## Filing a Claim

---

**How do I file a claim?** Obtain a claim form for the type of claim you are filing by:

- Calling Claims Customer Service at **1-800-788-6557** Monday through Friday, 8:00 a.m. to 8:00 p.m. ET
- Writing to Strategic Resource Company, Attn: AmeriCorps Claims, PO Box 23907, Columbia, SC 29224-3907.
- Contacting the AmeriCorps Program Director.

These claim forms contain instructions on how to fill them out (some forms include sections for your program to fill out).

Send completed forms to Strategic Resource Company, Attn: AmeriCorps Claims, PO Box 23907, Columbia, SC 29224-3907. Your doctor or dentist may prefer to file a claim for you using his or her own form. But if you have a claim, you must send in a signed claim form of the type utilized by this plan. This will help ensure prompt processing of your claim. If you have medical expenses resulting from an accident, you must provide full details of the accident on your completed claim form. The insurer reserves the right to require a medical examination at its expense. For Customer Service call **1-800-788-6557**, Monday through Friday, 8:00 a.m. to 8:00 p.m. ET.

**What if I have a Certificate of Creditable Health Coverage from a former employer?** If you submit it and it is approved, your pre-existing Waiting Period can be reduced, even eliminated. Make a copy of your certificate and send it to the claims address shown above. If you have lost your certificate, you may request another from the former employer.

**How do I (or a beneficiary) appeal a denied claim?** If all or a part of your claim is denied, you or the member's beneficiary will be provided a written explanation by the insurance company which will include:

- The specific reasons for the denial;
- Reference to the pertinent plan provisions upon which the denial is based;
- A description of any additional information you might be required to provide and explanation of why it is needed; and
- An explanation of the plan's claim review procedure.

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the insurance company. In connection with such a request, documents pertinent to the administration of the plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 180 days after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by the insurance company no longer than 60 days (45 days for term life or short term disability claims, if included in your plan) after receipt of the request for the review.

In the case of a claim involving urgent care, you will be notified of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request of an adverse benefit determination by the plan. A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (a) could seriously jeopardize the life or health of the claimant to regain maximum function, or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there are special circumstances, the decision will be made as soon as possible, but not later than 120 days (90 days for term life or short term disability claims, if included in your plan) after receipt of the request for the review. If such an extension of time is needed, you will be notified in writing prior to the beginning of the time extension period. The decision after your review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based.

Insurance plans are underwritten by  
Aetna Life Insurance Company.

Plans are administered by  
Strategic Resource Company (SRC).

MRG: V-001 ED-001 AMERICORPS (08/06)





# AmeriCorps Medical Benefits – Claim Instructions

**Warning:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

**Attention California Residents:** For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

**Attention Colorado Residents:** An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

**Attention New York Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

**Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.**

## TO THE MEMBER

1. Complete items one (1) through seventeen (17) in full.
2. Complete item 18 only if other medical coverage exists.
3. Be certain to sign the authorization to release information block (19).
4. If you wish to have your benefits for this claim paid directly to your physician or supplier, sign the block (20).
5. If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.
6. Attach itemized bills or ask your health care provider to complete the applicable section on the reverse side. The bills must include:
  - patient's name
  - date(s) of service(s)
  - condition being treated
  - relationship to member
  - type of service(s) rendered

If this information is missing, write it on the bill and sign your name.

7. If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. Receipt must contain:

- drug name	- strength
- dose per/day	- prescription number
- charge	- quantity
- purchase date	- physician's name
- nature of illness or injury	- pharmacy name/address

This information can be copied from the prescription bottle or box.

8. Retain copies of your bills for your record.
9. Send the completed benefits request and the bills to:  
**SRC, an Aetna Company**  
**Attn: Claim Department**  
**P.O. Box 23907**  
**Columbia, SC 29224-3907**  
**Fax to: 1-803-865-3798**  
**Phone: 1-888-772-9682**

## TO THE PHYSICIAN OR SUPPLIER

1. Complete items twenty-eight (21) through forty (39) in full.
2. If the member indicates that benefits should be paid directly to the physician or supplier, then these benefits will be sent directly to you with an information copy of the transactions to the member.



# AmeriCorps Medical Benefits Request

Mail to: SRC, an Aetna Company  
 Attn: Claim Department  
 P.O. Box 23907  
 Columbia, SC 29224-3907  
 Fax to: 1-803-865-3798  
 Phone: 1-888-772-9682

**TO BE COMPLETED BY MEMBER**

1. AmeriCorps Program Name		2. Policy/Group Number	
3. Member's ID Number	4. Member's Name		5. Member's Birthdate (MM/DD/YYYY)
6. Member's Address (include zip code) <input type="checkbox"/> Address is new			7. Member's Daytime Telephone Number ( )
8. Patient's Name	9. Patient's ID Number	10. Patient's Birthdate (MM/DD/YYYY)	11. Patient's Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Child
12. Patient's Address (if different from member)		13. Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	14. Patient's Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
15. Is claim related to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ time _____ <input type="checkbox"/> am <input type="checkbox"/> pm			16. Is claim related to AmeriCorps duties? <input type="checkbox"/> No <input type="checkbox"/> Yes
17. Are your expenses covered by another group health plan, group pre-payment plan (Blue Cross- Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? <input type="checkbox"/> No <input type="checkbox"/> Yes		18. If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator.	
19. To all providers of health care: You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. Patient's or Authorized Person's Signature _____ Date _____			
20. I authorize payment of medical benefits to the physician or supplier of service. Patient's or Authorized Person's Signature _____ Date _____			

**TO BE COMPLETED BY PHYSICIAN OR SUPPLIER**

21. Date of illness (first symptom) or injury (accident) or pregnancy (LMP)	22. Date first consulted you for this condition	23. If patient has had similar illness or injury, give dates	24. If an emergency check here <input type="checkbox"/> emergency
25. Date patient able to return to work	26. Date of total disability from _____ through _____		27. Date of partial disability from _____ through _____
28. Name of referring physician (e.g., Public Health Agency)		29. For services related to hospitalization give hospitalization dates admitted _____ discharged _____	
30. Name & address of facility where services rendered (if other than home or office)			
31. Diagnosis or nature of illness or injury (please indicate primary and secondary) 1. 2. 3. 4.			

**32. Procedures, Medical Services, Supplies Furnished**

Date of Service	Place of Service*	Procedure Code Identify**	Description of Service	Type of Service †	Charges	Days or Units	Diagnosis Code ††	Administrative Use Only

33. Physician's Name & Address (include zip code)	34. Telephone Number ( )	35. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.
	36. Patient Account Number	
38. Physician's or supplier's signature		37. Total charge \$ _____ Amount paid \$ _____ Balance due \$ _____
39. Date		

\* Place of Service Codes:  
 1 - (IH) - Inpatient Hospital      8 - (SNF) - Skilled Nursing Facility  
 2 - (OH) - Outpatient Hospital    9 -        - Ambulance  
 3 - (O) - Office Visit                0 - (OL) - Other Location  
 4 - (H) - Patient Home                A - (IL) - Independent Laboratory  
 5 -        - Day Care Facility (PSY)    B -        - Other Medical Surgical Facility  
 6 -        - Night Care Facility (PSY)   C - (RTC) - Residential Treatment Center  
 7 - (NH) - Nursing Home              D - (STF) - Specialized Treatment Facility

† Type of Service Codes:  
 1 - Medical Care                        8 - Assistance at Surgery  
 2 - Surgery                                9 - Other Medical Service  
 3 - Consultation                         0 - Blood or Packed Red Cells  
 4 - Diagnostic X-Ray                    A - Used DME  
 5 - Diagnostic Laboratory              M - Alternate Payment for Maintenance Dialysis  
 6 - Radiation Therapy                  Y - Second Opinion on Elective Surgery  
 7 - Anesthesia                            Z - Third Opinion on Elective Surgery

\*\* Please Use Current Procedural Terminology Codes For Surgery      †† Please Use ICD-9-CM For Discharge Diagnosis