

PRECERTIFICATION

You must request **precertification**, or precertify, certain care under the Standard **POS** option, **Salaried Retiree Indemnity** option, **Prescription Drug Program** and **Mental Health and Chemical Dependency Program** in order to receive the maximum available benefits under the Medical Plan. For some types of care, you must precertify the care to receive any benefits at all. **Precertification** is the process by which **Aetna** reviews the proposed treatment and advises you and your doctor as to what services can be covered under the Medical Plan.

Generally, precertified care is paid at the highest level of coverage. If you do not follow the **precertification** procedures when required, and it is later determined the treatment:

- *Is medically necessary*, benefits generally are paid at a *reduced* level or no payment is made, or
- *Is not medically necessary*, no benefits will be paid.

When You Must Precertify Care

Precertification is done by your **PCP** or **network specialist** if care is received **in-network** under the Standard **POS** option.

However, you are responsible for obtaining **precertification**:

- If you receive care for certain services **out-of-network** under the Standard **POS** option,
- If you receive care for certain services under the **Salaried Retiree Indemnity** option, or
- For services under the **Mental Health and Chemical Dependency Program**.

Prescription Drug Program benefits will be denied if drugs requiring precertification are not precertified. Your doctor must request the **precertification**, where applicable. See the **Prescription Drug Program** section for more information.

If you do not obtain **precertification** when required, benefits generally will be reduced or no benefits will be payable. For more information, see "Penalties if You Do Not Follow the Precertification Procedures."

Care You Must Precertify

Different medical options and programs have different **precertification** requirements. However, in cases where primary coverage is being provided by **Medicare**, services need to be precertified when they are not **covered** under **Medicare** or when **Medicare** benefits are being exhausted.

Under the POS Option

To receive the full amount of benefits available, **precertification** is required for certain **out-of-network** services under the Standard **POS** option. These include:

- **In-patient** confinements
 - Surgical and non-surgical confinements
 - Skilled nursing facility
 - Rehabilitation facility
 - Inpatient hospice (except Medicare)
 - Maternity confinements (for notification purposes only, please call after the first prenatal visit)
- Reconstructive procedures and procedures that may be considered cosmetic
 - Blepharoplasty/canthopexy/canthoplasty
 - Excision of excessive skin due to weight loss
 - Tattoo removal, revision or application
 - Rhinoplasty/rhytidectomy
 - Gastroplasty/gastric bypass
 - Pectus excavatum repair
 - Breast reconstruction/breast enlargement
 - Breast reduction/mammoplasty
 - Surgical treatment of gynecomastia

- Lipectomy or excess fat removal
- Treatment of penile dysfunction
- Sclerotherapy or surgery for varicose veins
- Any other potentially cosmetic procedure
- Selected durable medical equipment:
 - Electric or motorized wheelchairs and scooters
 - Clinitron and electric beds
 - Customized braces
 - Limb and torso prosthetics
- Medical injectables
 - Growth hormone
 - Intravenous immunoglobulin (IVIG)
- Orthognathic surgery procedures, osteotomies and surgical management of the temporomandibular joint
- The following **out-patient** surgeries:
 - Uvulopalatopharyngoplasty, including laser-assisted procedures
 - Laparoscopic infertility surgery
 - Bunionectomy and hammertoe surgery
- Elective (non-emergent) transportation by ambulance, or medical van and all transfers via air ambulance
- All home health care services
- Service by nonparticipating physicians and providers for non-emergent services requested at in-network level of benefits
- Dental implants and oral appliances

- Services that may be considered investigational or experimental

Under the Salaried Retiree Indemnity Option

To receive the full amount of benefits available, **precertification** is required for certain services under the **Salaried Retiree Indemnity** option. These include:

- Hospitalization*
- Admission to an **extended care facility**
- **Home health care agency** services
- **Private duty nursing**
- The following **out-patient** surgeries*:
 - Cataract surgery
 - Any type of foot surgery
 - Arthroscopy (examination or surgery on a joint using a fiber optic device)
 - Nasal endoscopy (examination or surgery of the nose or sinuses using a fiber optic tube)
 - Laparoscopy (examination or surgery in the abdomen using a fiber optic laser)
 - Lithotripsy (kidney stone fragmentation using ultrasound)

*If **Medicare** is primary for this service, you only need to precertify shortly before your **Medicare** benefits are exhausted.

Under the Mental Health and Chemical Dependency Program

To receive the full amount of benefits available under the **Mental Health and Chemical Dependency Program**, you must precertify **out-of-network** admissions to a **hospital**, acute psychiatric facility or acute **chemical dependency** facility. You must also precertify your **in-network** services.

How to Precertify

Under the Standard POS or Salaried Retiree Indemnity Option

If you are required to precertify care (see “Care You Must Precertify”), call the telephone number printed on your medical ID card (see “Important Contacts”). Generally, you should call at least seven days before the scheduled date of service or admission. For maternity care, you must certify your stay if it extends beyond 48 hours for a vaginal birth or 96 hours for a birth by cesarean section. For **urgent** care, call before receiving treatment or being admitted to the **hospital**. In an **emergency**, call **Aetna** Member Services within 48 hours.

When you call, be ready to give:

- The patient’s name, address, telephone number, age, identification number and relationship to you,
- All the information on your ID card,
- The type of care for which you are requesting **precertification**,
- The doctor’s name, address and telephone number, and
- If being admitted to a **hospital**, have the name, address and telephone number of the **hospital** available.

You and your doctor will be advised whether or not the care is precertified and, if applicable, the specific duration of time for which it is certified (applies for admission to a **hospital** or **extended care facility**, or for **home health care agency** services or **private duty nursing**). If care is precertified, a **precertification** number will be given. This number verifies that your treatment is precertified and no **precertification** penalties will apply. If you obtain the **precertification**, be sure to write the number down, along with the name of the person you spoke to and the date and time of your call.

If you do not obtain **precertification** when required, benefits will be reduced or no benefits will be payable. For more information, see “Penalties if You Do Not Follow the Precertification Procedures” and “Concurrent Review After Precertification.”

Under the Mental Health and Chemical Dependency Program

You, your **covered dependent** or the **provider** must call **Aetna** at the telephone number printed on your medical ID card (see “Important Contacts”) for an **in-network** or **out-of-network** admission to a **hospital**, acute psychiatric facility or acute **chemical dependency** facility. It is your responsibility to make sure the call is made and to know whether the admission is precertified. For **mental health emergency** admissions, you must call **Aetna** Member Services within 48 hours of being admitted. **Precertification** of **emergency** mental health treatment obtained from an emergency room is not required if you are not admitted, but it is recommended that you call **Aetna** regarding appropriate follow-up care. You must also precertify all **in-network** services by calling **Aetna**.

When you call, be ready to give:

- The patient’s name, address, telephone number, age and his or her relationship to you,
- Your (the retired Avaya Inc. employee’s) Social Security number,
- What you think the problem is or what the symptoms are (for example, drug use, depression or uncontrolled behavior),
- The name and telephone number of the **provider** currently treating the patient (for example, a psychiatrist or psychologist), and
- The name of the **hospital** where the patient will be admitted.

You and your doctor will be advised whether or not the admission is precertified. If it is precertified, you will be advised the number of days for which it is certified. If care is precertified, your doctor will get a **precertification** number. This number verifies your treatment is precertified and no **precertification** penalties will apply.

A call to **Aetna** to precertify an **out-of-network** admission only satisfies the **precertification** requirement. It does not entitle you to the **in-network** level of benefits, which is only available for precertified care through **in-network providers**.

If you do not obtain **precertification** for an **out-of-network hospital** admission, penalties will apply. For more information, see “Penalties if You Do Not Follow the Precertification Procedures” and “Concurrent Review After Precertification.”

Concurrent Review After Precertification

All precertified **in-patient** admissions, including admissions under the **Mental Health and Chemical Dependency Program, extended care facility stays, home health care agency services and private duty nursing**, are certified for a specific duration of time. Toward the end of the certified period, **Aetna** will follow up to see if your care will be completed as expected. If it is determined that treatment will take longer than originally expected, another review will be performed to determine whether an extension will be precertified. If it is not certified, *no additional benefits* will be paid for any treatment received after the duration of time that was originally certified.

Penalties if You Do Not Follow the Precertification Procedures

If you fail to follow the **precertification** procedures when required under the Standard **POS** option, **Salaried Retiree Indemnity** option, or **Mental Health and Chemical Dependency Program**, penalties will apply. These penalties are applied as benefit reductions. This means the level of benefits available will be reduced or no benefits will be paid for the treatment.

Under the Standard POS (for Out-of-Network Services) or Salaried Retiree Indemnity Option

A 20% benefit reduction, up to a \$400 maximum per occurrence, is applied to **covered** expenses if **precertification** is not obtained for:

- Hospitalization (**precertification** is not required for **emergency** care if you are not hospitalized), or
- Specific **out-patient** surgeries (see “Care You Must Precertify”).

After you pay \$400 in penalties, benefits for **covered** expenses revert back to the level of benefits usually available under your medical option, provided the care is found to be **medically necessary** upon review. However, if the review finds the hospitalization or surgery is not **medically necessary**, or if the treatment is not **covered** under your medical option, no benefits will be paid.

In addition, no benefits will be paid for **hospital** days beyond the number of days for which care was certified or if **precertification** is not obtained for:

- An admission to an **extended care facility**,
- **Home health care agency** services, or
- **Private duty nursing**.

You are responsible for paying these penalties. They will not count toward your annual **deductible** or **out-of-pocket maximum**.

Under the Mental Health and Chemical Dependency Program

A 20% benefit reduction, up to a \$400 maximum per occurrence, is applied to **covered** expenses if **precertification** is not obtained for an **out-of-network** admission to a **hospital**, acute psychiatric facility or acute **chemical dependency** facility for treatment of a mental health or **chemical dependency** condition.

After you incur \$400 in penalties, benefits for **covered** expenses revert back to the level of benefits usually available under the **Mental Health and Chemical Dependency Program**, provided the care is found to be **medically necessary** upon review. However, if the review determines the service is not **medically necessary**, or is not **covered** under the **Mental Health and Chemical Dependency Program**, no benefits will be paid.

You will be responsible for paying these amounts. They will not count toward your annual **deductible** or **hospital copayment** under the **Mental Health and Chemical Dependency Program**.