BENEFIT PLAN

Prepared Exclusively For
El Camino Hospital

OA Elect Choice EPO

Extraterritorial Riders

Aetna Life Insurance Company

These Extraterritorial Riders are part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

aetna™

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Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: El Camino Hospital

Group policy number: GP-0181066

Amendment effective date: January 1, 2025

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

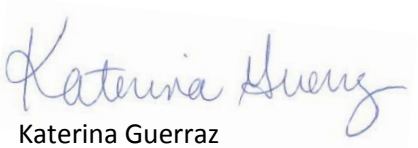
Important note: The following apply only if you live in Connecticut. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Precertification

Failure to pre-certify your eligible health services when required will result in a benefit reduction. Covered benefits will never be reduced by more than 50% of the benefits that would have been payable or $500, whichever is less.

How COB works with Medicare

When you are covered under Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare.
This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

Amendment: Connecticut Medical ET
Issue Date: February 20, 2025

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: El Camino Hospital

Group policy number: GP-0181066

Amendment effective date: January 1, 2025

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Florida. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Cleft lip and palate

Covered services include treatment for a congenital cleft lip or cleft palate. This includes:

- Orthodontics
- Oral **surgery**
- Otologic services
- Nutrition services
- Audiological and speech/language treatment involved in the management of birth defects known as cleft lip, cleft palate or both

Jaw joint disorder treatment

Covered services include the diagnosis, surgical and non-surgical treatment of **jaw joint disorder** by a **provider**, including:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

The following are not **covered services**:

- Non-surgical dental services, and therapeutic services related to **jaw joint disorder**

The following has been added to or replaced in the *Eligibility, starting and stopping coverage, Who can be a dependent on this plan* section of your booklet-certificate.

- Dependent children – yours or your spouse's or partner's
    - A dependent child who is under 26 years of age will be covered until the end of the calendar year after they have reached age 26 provided they meet all of the following:
        - Attending school regularly (full-time or part-time) or living in your household
        - Solely dependent upon you for support
    - A dependent child from the end of the calendar year in which the child turns age 26 until the end of the calendar year in which the child turns age 30, provided the child is:
        - Unmarried and does not have a dependent of their own
        - A resident of Florida or a full-time or part-time student
        - Not eligible for Medicare and not covered under another group, blanket, franchise or individual health benefit plan

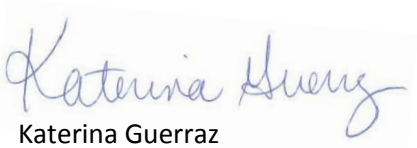
The following has been added to or replaced in the *We end your coverage* section of your booklet-certificate.

Why would we end your coverage?
Your coverage may end if you act in a way that prevents you from having a good relationship with a **network provider**. We may also end your coverage if you act in a way that affects our business operations. We will give you 45 days notice in writing if we end your coverage for any of these reasons.

We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayment for periods after the date your coverage ended.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Katerina Guerraz
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(A Stock Company)

Amendment: Florida Medical ET
Issue Date: February 20, 2025

The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: El Camino Hospital

Group policy number: GP-0181066

Amendment effective date: January 1, 2025

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Georgia. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Ambulance/Emergency Services

If your plan includes coverage for expenses related to non-emergency use of the emergency room, those expenses will also apply towards your plan's **maximum out of pocket limit**. If your plan includes coverage for out-of-network expenses, non-emergency ambulance services received from an **out-of-network provider** or other health care provider are paid the same as in-network. If your plan includes coverage for out-of-network expenses and provides coverage related to non-emergency care in a hospital emergency room, those expenses received from an **out-of-network provider** or other health care provider are paid the same as in-network.

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Dental care anesthesia

Covered services include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist's office due either to age or medical condition.

The following are not **covered services**:

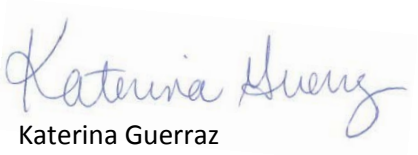
- The related dental service unless specifically listed as a **covered service** in this certificate

Jaw joint disorder treatment

Covered services include the diagnosis, surgical and non-surgical treatment of **jaw joint disorder** by a **provider**, including:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

Amendment: Georgia Medical ET
Issue Date: February 20, 2025

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: El Camino Hospital

Group policy number: GP-0181066

Amendment effective date: January 1, 2025

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Indiana. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Questions regarding your policy coverage should be directed to Aetna by calling the toll-free number on your ID card

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

Indiana Department of Insurance
Consumer Services Division
311 West Washington Street
Suite 300
Indianapolis, IN 46204
Consumer Hotline: (800)-622-4461 or (317)-232-2395
Complaints can be filed electronically at https://www.in.gov/idoi

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your civil union partner who meets any policyholder rules and requirements under state law
- If your plan allows, your domestic partner who meets policyholder rules and requirements under state law
- Dependent children – yours or your spouse's or partner's (if allowed)
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption

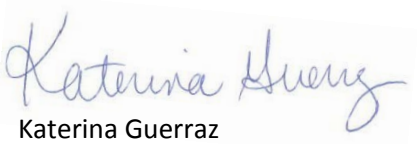
- Foster children
- A child subject to legal guardianship
- Children you are responsible for under a qualified medical support order or court order
- Grandchildren in your legal custody

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
  - If you are either:
    - Younger than age 45, but considered to be at high risk
    - Age 45 or older
- Digital rectal exams (DRE)
  - Younger than age 45, but considered to be at high risk
  - Age 45 or older
- Double contrast barium enemas (DCBE)
  - Younger than age 45, but considered to be at high risk
  - Age 45 or older
- Fecal occult blood tests (FOBT)
  - Younger than age 45, but considered to be at high risk
  - Age 45 or older
- Lung cancer screenings
- Mammograms
  - One mammogram if you are age 35 through 39
  - One mammogram per year if you are either:
    - Younger than age 40, but considered to be at risk
    - Age 40 or older
- Prostate specific antigen (PSA) tests
  - Younger than age 50, but considered to be at high risk
  - Age 50 or older
- Sigmoidoscopies
  - Younger than age 45, but considered to be at high risk
  - Age 45 or older

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Katerina Guerraz
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Aetna Life Insurance Company
(A Stock Company)

Amendment: Indiana Medical ET
Issue Date: February 20, 2025

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: El Camino Hospital

Group policy number: GP-0181066

Amendment effective date: January 1, 2025

Your group policy has changed. The certificate of coverage and schedule of benefits are revised to reflect this. This change is effective on the date shown above.

Important note: The following apply only if you live in Louisiana. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate:

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

Ambulance service

An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Emergency

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another if the first **hospital** can't provide the **emergency services** you need
- When your condition is unstable and requires medical supervision and rapid transport
- For your newly born child and disabled mother to a **hospital** or neonatal unit

Non-emergency

Covered services also include precertified transportation to a **hospital** by a licensed ambulance:

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; limited to 100 miles
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment
- For your newly born child and disabled mother to a **hospital** or neonatal unit

For the purpose of this benefit:

- A “newly born child” means a child from birth to one month old, or until the infant is well enough to go home. This may take longer than one month.
- A “disabled mother” means a woman who has recently given birth and whose **physician** has advised her that normal travel may be harmful to her health.

The following are not **covered services**:

- Ambulance services for routine transportation to receive outpatient or inpatient services

Autism spectrum disorder

Autism spectrum disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Covered services include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech and language pathology therapy associated with the diagnosis of autism spectrum disorder

Cleft lip and cleft palate

Covered services include the treatment and correction of cleft lip and palate. This coverage shall include benefits for secondary conditions and treatment attributable to that primary medical condition. **Covered services** include services and supplies:

- Oral and facial **surgery**, including care by a **physician** before and after **surgery**
- Prosthetic treatment such as:
  - Obturators
  - Speech appliances
  - Feeding appliance
- Orthodontic treatment and management
- Preventive and restorative dentistry to ensure good health
- Adequate dental structures for orthodontic treatment
- Prosthetic management or therapy
- Speech-language evaluation and therapy
- Audiological assessments and management
- Otolaryngology treatment
- Psychological assessment and counseling
- Genetic assessment and counseling for you, your dependent child and the child’s parents

A “legally qualified audiologist’ or “speech therapist” is considered a **physician** that can provide this coverage.

These benefits will be paid on the same basis as any other illness or injury.

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include drugs devices, prevention, detection, treatments, or procedures from a **provider** under an "approved clinical trial" only when you have cancer or other life-threatening disease or condition.

A "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

Dental care anesthesia

Covered services include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist's office due to either age or medical condition.

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** in this certificate.

Diabetic services, supplies, equipment, and self-care training and education programs

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Self-management training and education provided by a health care **provider** certified in diabetes self-management training, including medical nutrition therapy

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Genetic or molecular testing for cancer including but not limited to:
  - Tumor mutation testing
  - Next generation sequencing
  - Hereditary germline mutation
  - Whole exome and genome sequencing
  - Biomarker testing
- Advanced molecular techniques for a critically ill infant including but not limited to:
  - Traditional whole genome sequencing
  - Rapid whole genome sequencing
  - Other genetic and genomic screenings that include:
    - Individual sequencing
    - Trio sequencing for a parent or parents of the infant
    - Ultra-rapid sequencing for an infant one year of age or younger that is receiving inpatient services in an intensive care unit or a pediatric care unit and has a complex illness of unknown etiology
- Other tests

These are covered only when you get them from a licensed radiology **provider** or lab.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned services that are proven to result in **infertility** such as:
  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
  - **Surgery** or other medical treatment for cancer that is established by the American Society for Reproductive Medicine or the American Society of Clinical Oncology
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna's **infertility** clinical policy

Covered services include:

- Evaluation
- Labs
- Medication and treatment associated with oocyte and sperm cryopreservation procedures, including obtaining, freezing and storing gametes for three (3) years

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators. They can help with determining eligibility for benefits. You can call the NIU at 1-800-575-5999.

Jaw joint disorder treatment

Covered services include the diagnosis, therapeutic services, surgical and non-surgical treatment of **jaw joint disorder** by a **provider**, including:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

Nutritional support

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

The following are not **covered services**:

- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - Medical foods
  - Other nutritional items

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services, including maternity support provided by a doula before, during and after childbirth. After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

Covered services also include inpatient and outpatient use for up to 2 months of **medically necessary** donated pasteurized human breast milk obtained from a milk bank when prescribed by a licensed **health professional** for an infant who is medically or physically unable to receive maternal human breast milk or participate in chest feeding or whose mother is medically or physically unable to produce maternal human breast milk in sufficient quantities.

If the mother is discharged earlier, the plan will pay for 1 home visit after delivery by a health care **provider**. **Covered services** also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Mail order pharmacy
The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. A **mail order pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

Prescriptions can be filled at a network **mail order pharmacy**.

Anti-cancer drugs taken by mouth, including chemotherapy drugs
Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment. We pay oral and anti-cancer drugs the same as intravenous (IV) anti-cancer drugs.

Prosthetic devices and services

Eligible health services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers. This includes the services related to the initial provision and replacement of a prosthetic device. But we cover it only if we approve the device or service in advance.

Prosthetic device means:

- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of **illness** or **injury** or congenital defects.

Coverage includes:

- Repairing or replacing the original device you outgrow or that is no longer is appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Instruction and other services (such as attachment or insertion) so you can properly use the device

Reconstructive breast surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- All stages of reconstruction of the breast on which a unilateral mastectomy has been performed and on the other breast to produce a symmetrical appearance including:
  - Contralateral prophylactic mastectomies
  - Liposuction performed for transfer to a reconstructed breast or repair donor site deformity
  - Tattooing the areola of the breast
  - Surgical adjustments of the of the non-mastectomized breast
  - Unforeseen medical complications which may require additional reconstruction in the future
  - Prostheses and physical complications
  - Lymphedema
- All stages of reconstruction of both breasts if a bilateral mastectomy has been performed including:
  - Liposuction performed for transfer to a reconstructed breast or repair donor site deformity
  - Tattooing the areola of the breast
  - Unforeseen medical complications which may require additional reconstruction in the future
  - Prostheses and physical complications
  - Lymphedema
- Breast reconstruction procedures to be performed shall be made solely by the patient in consultation with attending **physicians** regardless of whether a partial mastectomy or a full unilateral or bilateral mastectomy is chosen by the patient and **physician**

- Preventive cancer screenings, on no less than an annual basis, for an insured or enrollee who:
  - Was previously diagnosed with breast cancer
  - Completed treatment for breast cancer
  - Underwent a bilateral mastectomy
  - Was subsequently determined to be clear of cancer

Well woman preventive visits

A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Office visit to a **physician**, **PCP** (if applicable to your plan), OB, GYN or OB/GYN for services including annual Pap smears
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Capsule colonoscopy
- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- CT colonoscopy
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal immunochemical test (FIT) for blood
- Fecal immunochemical test (FIT) – fecal DNA test
- Flexible Sigmoidoscopies
- Lung cancer screenings
- Mammograms including diagnostic imaging and ultrasound screening designed to evaluate an abnormality
- Prostate specific antigen (PSA) tests*
- Sigmoidoscopies

Important note:
*Prostate cancer screening includes a second visit when **medically necessary** and follow-up treatment within sixty days after either visit, if related to a condition diagnosed or treated during the visits.

Telehealth

Covered services include **telehealth** consultations when provided by a **physician**, **specialist, behavioral health provider** or other **telehealth provider** acting within the scope of their license.

Covered services for **telehealth** consultations are available from a number of different kinds of **providers** under your plan. Log in to your member website at https://www.aetna.com/ to review our **telehealth provider** listing and contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

- Telephone calls, except if after access and review of the patient's medical records, the **physician**, **specialist**, **behavioral health provider** or other **telehealth provider** decision meets the same standard of care if the health care services were provided in person
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Treatment of metastatic or unresectable tumors

Covered services include FDA-approved drugs used for the treatment of metastatic or unresectable tumors, even if the drug isn't approved by the FDA for this treatment. After an initial treatment period of a minimum of 3 months, treatment can continue if your treating **physician** certifies the drug have created a document improvement in your condition. If a type of treatment has been documented through clinical trials as being more effective for your condition, we may deny coverage for these drugs.

Important note
You or your **employer** are responsible for the payment of any tax that applies to **prescription** drugs that are **covered services** under your plan. Please check with your **employer**.

Translation charges

Covered services include services for translation charges for a qualified interpreter/translator related to covered medical treatment or diagnostic consultations performed by a **physician**. This is available to you if the services are required because you are deaf, hard of hearing, have a hearing loss or you cannot understand or communicate in spoken language. The interpreter/translator cannot be a family member.

The following has been added to or replaced in the *How your plan works* section of your booklet-certificate:

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network
- You are already an Aetna member and your **provider** stops being in our network

But, in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

If this situation applies to you, contact us for details If you are undergoing treatment for an acute or chronic condition and the **provider** didn't leave the network based on fraud, lack of quality standards, you'll be able to receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

Important note:
If you are pregnant and have entered your second trimester, or are diagnosed to have a high risk pregnancy, transitional care will be through the time required for postpartum care directly related to the delivery.

If you have been diagnosed with a life-threatening illness, the transitional period will be until your course if treatment is completed. It will not exceed 3 months from the date the **provider** terminated their participation with Aetna.

"Life-threatening illness" means a severe, serious, or acute condition for which death is probable.

This provision does not apply:

- If you:
  - Move out of the geographic service area of the Plan
  - Choose to change **provider**
  - Requires only routine monitoring for a chronic condition but is not in an acute phase of the health condition

- If the **provider**:
  - Moves out of the geographic service area of the Plan
  - Does not consent to continue to provide services

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.
Certain **prescription** drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following **precertification** information applies to these **prescription** drugs:

Step therapy

A form of **precertification** under which certain **prescription drugs** are excluded as coverage unless a first-line therapy drug is first used by you. The list of step therapy drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to step therapy is available upon request on our website at https://www.aetna.com/individuals-families/find-a-medication.html. We will also tell you which drugs are excluded from the step therapy process.

We will make a therapy determination within 72 hours of receiving all the claim information from the prescribing **provider**. Urgent situations will be handled within 24 hours of receiving all the clinical information from the prescribing **provider**. Step therapy exception requests from the prescribing **provider** must clinically show that one of the following is true:

- The preferred treatment has been ineffective in the past treatment the patient's disease or medical condition while tried during the patient's current or previous health insurance plan.
- The preferred treatment can be expected to be ineffective based on known physical or mental characteristics of the patient vs. characteristics of the drug regimen.
- The preferred treatment is contraindicated or will likely cause an adverse reaction to the patient.
- The patient is currently receiving a positive outcome on the requested **prescription** drug for the medical condition in question under their current health plan or immediately preceding health plan, under which the drug was a covered benefit.
- The preferred treatment is not in the best interest of the patient as evidenced by valid documentation submitted by the prescriber.

If the step therapy exception request submitted by the **provider** meets any of the clinical criteria above, and the agreed to turn around time is missed, we agree to deem the request as approved.

Contact us or go online to get the most up-to-date **precertification** requirements and list of step therapy drugs.

Requesting a medical exception
Sometimes you or your **provider** may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members. For directions on how you can submit a request for a review:

- Call the toll-free number on your ID card
- Log in to your member website at https://www.aetna.com/
- Submit the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road, Richardson, TX 75081

You, someone who represents you, or your **provider** may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your prescriber of our decision. If approved by us, the exception will apply for the entire time you have an urgent situation.

If you are denied a medical exception based on the above process, you may have the right to a third party review by an independent review organization. If our claim decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send represents you or your prescriber of the coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the **prescription**. For quicker medical exceptions in urgent situations, we will tell you, or someone who represents you or your prescriber of the coverage determination no later than 24 hours after we receive you request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation. See the *External review* section for the IRO process.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, you should file your claim with each plan. We will work with your other plan to decide how much each plan pays. This is called coordination of benefits (COB).

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The plan that pays after the Primary plan is Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total.

Key Terms

Here are some key terms we use in this section. These will help you understand this COB section.

Allowable expense means:

- A health care service expense, including **deductibles**, **coinsurance** and **copayments**, that is covered in full or at least in part by any plan covering the person. Where a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and will be paid.

Claim determination period or plan year:

- A period of not less than 12 consecutive months over which allowable expenses shall be compared with total benefit payable in the absence of COB to determine whether over-insurance exists and how much each plan will pay or provide:
  - The claim determination period is usually a calendar year, but a plan may use some
  - other period of time that fits the coverage of the group or individual contact. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.
  - As each claim is submitted, each plan determinations its responsibility and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination.

Closed panel plan(s) means:

- A plan that provides **covered services** to covered persons primarily in the form of services through a participating **provider** and that excludes coverage for services provided by non-participating **providers**, except in cases of emergency or referral by a **provider**.

Custodial parent means:

- The parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

In this section when we talk about "plan" through which you may have other coverage for health care expenses for medical or dental treatment, we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Closed panel plans or other forms of group or group type coverage (whether insured or not insured)
- Medical care components long-term care contracts, such as skilled nursing care
- Group and non-group coverage through closed panel plans
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medical benefits under a group or individual automobile insurance policy
- Medicare or any other federal government plan, as permitted by law
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

A plan does not include:

- Hospital indemnity coverage
- Accident only
- Specified disease or specified accident coverage
- Limited benefit health coverage, as defined by law
- School accident type coverage
- Benefits for non-medical components of group, long-term care policies
- Medicare supplement policies
- Medicaid policies
- Coverage under other federal governmental plans, unless permitted by law

Each contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

How COB works

- When this is the primary plan, we pay your medical claims first as if the other plan does not exist
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid
- We will never pay an amount that, together with payments from your other coverage, adds up to more than 100% of the allowable expenses

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

Any plan that does not contain your state's COB provision is always the primary plan pursuant to Regulation 32 COB Model.

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan:
  - Except as provided in paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.
  - Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by contract holder.
  - Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- Each plan determines its order of benefits using the first of the following that apply:

COB rule if you are covered as a:	Primary Plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Exception to the rule above when you are a Medicare beneficiary	If you or your spouse is a Medicare beneficiary: • And as a result of federal law, Medicare is secondary to the plan covering you or your spouse as a dependent • And primary to the plan covering the person as other than a dependent (e.g. a retired **employee**) • Then the order of benefits between the two plans is reversed so that the plan covering the person as an **employee** or retired **employee** is the secondary plan and the other plan is the primary If you have any questions about this you can contact us: • See the section *How COB works with Medicare* below. • Online: Log on to your secure member website at www.aetna.com. • Select Find a Form, then select Your Other Health Plans. • By phone: Call the toll-free number on your ID card.	Same rule under Primary plan
Child of - Parents married or living together, whether or not they have ever been married	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule*) *Same birthdays – the plan that has covered a parent longer is primary	Plan of parent whose birthday* is later in the year *Same birthdays – the plan that has covered a parent longer is primary

COB rule if you are covered as a:	Primary Plan	Secondary plan
Child of: • Parents separated, divorced, or not living together, whether or not they have been married and the plan of that parent has actual knowledge of the terms, that plan is primary • With court-order will apply to plan years beginning after the plan has given notice or the court-order	• Plan of parent responsible for health coverage in the court order • If that parent has no coverage then their spouse's plan is primary	• Plan of other parent • If the parent has no coverage then their spouse's plan is primary
Child of: • Parents separated, divorced, or not living together, whether or not they have been married and the court-order states both parents are responsible for health coverage or have joint custody where the court did not state that one parent is responsible for health coverage	Primary coverage is based on the birthday rule	Secondary coverage is based on the birthday rule
Child of: • Parents separated, divorced, or not living together, whether or not they have been married and there is no court-order that states which parent is responsible for health coverage	The order of benefits payment is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	• See rule under Primary plan
Child covered under: More than one plan by an individual who is not a parent (i.e. stepparent or grandparent)	Treats the person the same as a parent when making the order of benefits determination: See all "Child of" content above	Same rule as Primary plan

COB rule if you are covered as a:	Primary Plan	Secondary plan
Child covered by the spouse's plan is: • When the child has health coverage under either or both parents' plans and also has health coverage a dependent under the spouse's plan	See "Longer or shorter length of coverage" shown below	Same rule as Primary plan
Child covered by the spouse's plan: • In the event the child's health coverage under the spouse's plan began on the same date as the health coverage under either or both parents' plan	Primary and secondary coverage is based on the birthday rule of the child's parent or spouse See "Child of" content below	Same rule as Primary plan
Active or inactive **employee**	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree) is primary to COBRA or under a state or other Federal continuation of coverage If the other plan does not have this rule, as a result, the plans do not agree on the order of benefits, this rule is not applied	COBRA or state or other Federal continuation coverage If the other plan does not have this rule, as a result, the plans do not agree on the order of benefits, this rule is not applied
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	If none of the above rules apply, the plans share the allowable expenses equally between the plans meeting the definition of "plan" shown in the "key terms" above This plan will not pay more than it would had it been the primary plan	If the other plan does not have this rule, as a result, the plans do not agree on the order of benefits, this rule is not applied This plan will not pay more than it would had it been the primary plan

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved
Secondary plan	Effect of the benefits when the plan is secondary: • It may reduce its benefits so that the plans during a year are not more than the total allowable expenses • In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan • May then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim • Shall credit to its plans **deductible**, **coinsurance**, **copayments** and any amount it would have credited to its **deductible** in the absence of other health care coverage • It may reduce its benefits so that the total benefits paid or provided by all plans during a plan year or claim determination period are not more than 100% of total allowable expenses
Benefit reserve*	The benefit reserve when this plan is the secondary plan: • Is the difference between the benefit payments that this plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period • As each claim is submitted will determine: – Its responsibility to pay or provide benefits under its contract – Whether a benefit reserve has been recorded for the covered person – Whether there are any unpaid allowable expenses during that claims determination period • Will use the covered person's benefit reserve to pay up to 100% of the total allowable expenses incurred during the claim determination period

	• At the end of the claim determination period, the benefit reserve returns to zero • A new benefit reserve must be created for each new claim determination period

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel **provider**, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

*Note:
You may request either a paper copy or electronic form of an Appendix C. It will provide you with an explanation for secondary plans on:

- The purpose and use of the benefit reserve
- How secondary plans calculate claims

You can request a copy of the Appendix C by contacting us:

- Online: Log on to your secure member website at www.aetna.com
- By phone: Call toll-free number on your ID card

How COB works with Medicare

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

If you are a Medicare beneficiary, the plan coordinates benefits we pay with the benefits that Medicare pays. -Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare.

You are a Medicare beneficiary if you are covered under it by reason of age, disability or end stage renal disease. With respect to Medicare part B, even if you are not covered because you refused it, dropped it, or didn't make a request for it.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The **employer** has 20 or more **employees**	Your plan	Medicare
You are retired	Medicare	Your plan

If you have Medicare because of:

End stage renal disease (ESRD)	Your plan will pay first for the first 30 months Medicare will pay first after the 30 months	Medicare Your plan

A disability other than ESRD and the policyholder has more than 100 **employees**	Your plan	Medicare

Note regarding ESRD: If you are already a Medicare beneficiary due to age and then became eligible due to ERSD, Medicare will remain your primary plan and this plan will be secondary.

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved
Medicare is primary	We calculate our benefits as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expenses

Charges that satisfy Part B **deductible** will be applies in the order received. We will apply the largest charges first when two or more charges are received at the same time.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

Right to receive and release needed information

There are certain facts about your health coverage and services that are needed to:

- Apply COB rules
- Determine benefits payable under this plan or other plans

We may get the facts we need from or give them to other plans or persons for the purpose of:

- Applying theses rules
- Determining benefits that will be paid from the plan covering you or your family member claiming benefits under this plan and other plans covering the person claiming benefits.

We do not need to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give us any facts we need to apply those rules and determine benefits payable.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When this happens, we will pay your plan benefit to the other plan. That amount will be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services. In which case, "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of recovery

If we pay more than we should have under the COB rule, we may recover the excess from:

- One or more of the persons we paid or for whom we paid
- Any other person or plan that may be responsible for the services provided for the covered
- person under these COB rules

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services.

Summary of Coordination of benefits procedures

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures and does not change or replace the language contained in the, certificate which determines your benefits.

Double coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both **employers**. When you are covered by more than one health plan, state law allows your insurers to follow coordination of benefits procedure to determine how much each plan pays when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses. Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of come of the most common ones. Read your contract carefully. If your situation is not described, contact your state insurance department.

Primary or secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine where we are the "Primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

A plan that does not contain your states COB rules according to Regulation 62 COB Model will always be primary.

When this plan is primary

If you or a family member are covered under another plan in addition to this one, we will be primary. When we will be primary, see the chart under "Determining who pays" for:

- Your own expenses
- Your spouse's expenses
- Your child's expenses

Other situations
We will be primary when any other provisions of state or federal law require us to be.

How we pay claims when we are primary
When we are the primary plan, we will pay the benefits in accordance with the terms in your certificate just as if you had no other health care coverage under any other plan.

How we pay claims when we are secondary
We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan; we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care service or expense covered by one of the plans, including **copayments**, **coinsurance** and **deductibles**.

- If there is a difference between the amount the plans allow, we will base our payments on the
- higher amount. However, if the primary plan has a contract with **provider**, our combined
- payments will not be more than the contract calls for. Health maintenance organizations (HMOs) and preferred provider (PPOs) usually have contracts with their **providers**.
- We will determine our payment by subtracting the amount the primary plan paid from the
- amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefits because you did not obtain pre-authorization, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.
- Benefit reserve
- When are secondary we often will pay less than we would have paid if we had been primary.
- Each time we "save" by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the saving. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans. Savings can build up in your reserve for one year. At the end of the year for each balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

Questions about Coordination of Benefits?
Contact your state insurance department

The following has been added to or replaced in the *How your plan works* section of your booklet-certificate:

Benefit payments and claims

A claim is a request for payment that you or your health care **provider** submits to us when you want or get **covered services**. There are different types of claims. You or your **provider** may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within *How your plan works*. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes

Urgent care claim

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision as soon as possible or within 2 days. If additional information is needed, we will tell you our decision as soon as possible, but no later than 48 hours from receipt of the additional information.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 2 days, or within 5 days if clinical information is required.

Post-service claim

A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

Concurrent care claim extension

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision as soon as possible but not less than 24 hours for an urgent request, or 72 hours if clinical information is required and received more than 24 hours after request. You may receive the decision for a non-urgent request within 15 days.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an independent review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as **copayments**, **coinsurance** and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

Adverse benefit determinations (decision) are any of the following:

- We pay many claims at the full rate negotiated charge with a **network provider** and the **allowable amount** with an **out-of-network provider**, except for your share of the costs. Sometimes we pay only some of the claim and sometimes we don't pay at all.
- A review that denies, reduces, terminates or fails to provide or make a payment in full or in part, for the benefit based on a determination by us or its review organization of the covered person's eligibility to participate in our health benefit plan.
- Any pre-service review or post-service review that denies, reduces, or terminates, or fails to provide or make payment, in whole or in part, for a benefit under the health plan.
- A rescission of coverage determination. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.
- External reviews shall apply only to adverse benefit determinations and final adverse benefit determination that involve:
  - Medical judgement
  - Appropriateness
  - Health care setting
  - Level of care
  - Effectiveness of a covered benefit
  - A service, supply, or treatment is experimental or investigational
  - Rescission

Authorized representative

- A person to whom you have given express written consent to represent you. It may also include your treating **provider** if you appoint the **provider** as your authorized representative and the **provider** waives, in the writing, any right to payment from you other than any applicable **copayment** or other **coinsurance** amount. In the event that the service is determined not to be **medically necessary** and you or your authorized representative, except for your treating **health professional**, thereafter requests the services, nothing shall prohibit the **provider** from charging usual and customary charges for all non-medically necessary services provided.
- A person authorized by law to provide substituted consent for you.
- Your immediate family member or your treating **health professional** when you are unable to provide consent.
- In the case of an urgent care request, a **health professional** with knowledge of your medical condition.

Grievance

A grievance is a type of written or oral compliant, it may involve an urgent care request on your behalf. about any of the following:

- The availability, delivery or quality of health care services
- How we paid, handled or reimbursed your claim
- Our contractual documents and your plan benefits

You or your provider can call the toll-free number on the back of your ID card or write Member Services at P.O. Box 14462 Lexington, KY 40512 to let us know about your grievance.

Filing a claim

When you see a **network provider**, that office will usually send us a detailed bill for your services. [If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 12 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, **providers** and cost of your services.

The benefit payment determination is made based on many things, such as your **deductible** or **coinsurance**, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay a paper claim within 45 days and an electronic claim within 25 days from when we received all of the information necessary. When a paper claim is submitted 45 days after the date of service, we will pay that claim within 60 days. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions and, appeal procedures* section for that information.

The following has been added to or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets policyholder rules and requirements under state law
    - To be eligible for coverage, a domestic partner is a person who certifies the following as of the date of enrollment:
        - He or she is your sole domestic partner and intends to remain so indefinitely
        - He or she is not married or legally separated from anyone else
        - He or she is not registered as a member of another domestic partnership within the past 6 months
        - He or she is of the age of consent in your state of residence
        - He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside
        - He or she has cohabitated and resided with you in the same residence for the past 6 months and intends to cohabitate and reside with you indefinitely
        - He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses
        - He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage
        - He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
            - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property
            - Common ownership of a motor vehicle
            - Driver’s license with a common address
            - Proof of joint bank accounts or credit accounts

    - Proof of designation as the primary beneficiary for life insurance or retirement benefits or primary beneficiary designation under your will
    - Assignment of a durable property power of attorney or health care power of attorney.
- Dependent children – yours or your spouse's or partner's
    - Dependent children must be under age 26, and they include:
        - Natural children
        - Stepchildren
        - Adopted children including those placed with you for adoption
        - Foster children
        - Children you are responsible for under a qualified medical support order or court order
        - Grandchildren in your legal custody
        - A grandchild whose parent is already covered as a dependent on this plan
        - Any child placed in your home due to the execution of an act of voluntary surrender

"Placed with you for adoption" means, you have taken on the legal obligation for total or partial support of a child whom you plan to adopt. The child's placement with you ends when your legal obligation ends.

To enroll an out of area dependent on this plan (if applicable to your plan):

- You must be enrolled as an **employee** in a different Aetna plan option offered by the **policyholder**
- Your eligible dependent must live outside your plan's service area

The following has been added to or replaced in the *Complaints, claim decisions and appeal procedures* section of your booklet-certificate:

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

Claim decisions and appeal procedures

Your **provider** may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in *Benefit payments and claims* in the *How your plan works* section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an "adverse benefit determination" or "adverse decision." For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don't agree, you can also appeal that decision. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer for a level 1 and 2 within 36 hours. We will also give you an answer within 15 calendar days for a level 1 pre-service appeals and within 5 days for a level 2 pre-service appeal. A concurrent claim appeal will be addressed 2 days after the adverse determination.

Any other claim appeal

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

- Your name
- The plan sponsor's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

You can appeal two times under this plan. We call these a level 1 and level 2 appeal. If you are still not satisfied with the answer of the first internal appeal (level 1), you may make a second internal appeal, (level 2). You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

You may contact the Louisiana Department of Insurance for help is submitting an appeal:

Louisiana Department of Insurance
Office of Consumer Services
Post Office Box 94214
Baton Rouge, LA 70804

You may also call the toll-free number 1-800-259-5300 or visit the LDI website at www.ldi.la.gov.

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on your member website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

Exhaustion of appeal process

In most situations, you must complete the two levels of appeal with us before you can take these other actions:

- Contact the Louisiana Department of Insurance to request an investigation of a complaint or appeal
- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

Sometimes you do not have to complete the two levels of appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of Louisiana. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

External review

External review is a review done by people in an organization outside of Aetna. This is called an independent review organization (IRO). The types of External reviews are:

- Standard external review
- Expedited external review
- Standard external review or Expedited external review of an experimental or investigational treatment

You have the right to an external review only if you received an adverse determination or final adverse determination where:

- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary** or not appropriate
- We decided the health care setting, level of care, or effectiveness of the service or supply does not meet the requirements under your health plan
- We decided the service or supply is experimental or investigational treatment
- We rescind your coverage

You may also request external review if you want to know if the federal surprise bill law applies to your situation.

You may ask for an external review. The notice of adverse benefit determination or final adverse benefit determination we send you will also describe the external review process. It will include a copy of the request for external review form at the final adverse determination level.

You may make an oral or written request for external review form. Your request should be submitted:

- To Aetna
- At the time that you receive the decision from Aetna of an adverse determination or final adverse determination, when you are requesting an expedited external review
- Within 4 months of the date you received the notice of the decision from Aetna of an adverse determination or final adverse determination, when you are requesting a standard external review or a standard or expedited external review for experimental or investigational treatment
- With a copy of the notice from us, along with any other important information or materials that supports your request

Upon request and free of charge, we will provide you with copies of all documents about your claim. We will pay for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

We will:

- Notify the Louisiana Department of Insurance of the request for an external review
- Submit a request for assignment to an independent review organization (IRO)

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the IRO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IRO decision?
The IRO will give us, you and the Louisiana Department of Insurance a decision not more than 45 calendar days after we receive your notice of external review form with all the information you need to send in.

Sometimes you can get an expedited external review decision. You or your authorized representative must call us or send us a request for external review form.

There are scenarios when you may be able to get an expedited external review:
For initial adverse benefit determinations

- Your **provider** tells us a delay in receiving health care services would:
  - Jeopardize your life, health or ability to regain maximum function
  - Be much less effective if not started right away and can cause an imminent threat to your health (in the case of **experimental or investigational** treatment)

For final adverse determinations

Your **provider** tells us a delay in receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away and can cause an imminent threat to your health (in the case of **experimental or investigational** treatment), or
- The final adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility

Timeframes for external review decisions

The amount of time it takes for a final decision from the IRO depends on the type of review. The chart below shows a timetable view of the different types of review.

Type of external review	**When we complete a preliminary review of the request and notify you**	**When the review request is assigned to the IRO**	**When the IRO completes their review and notifies you**
Standard external review	Within 5 business days after the date of receipt of the notice	Within 1 business day after receiving request from Aetna	Within 45 days after the date of receipt of the request to complete the review, or IRO has 1 business day after making their decision to send a written notice, if Aetna fails to provide the documents and information within the requested timeframe
Expedited external review (oral or written)	Immediately after receiving request	Immediately after receiving request from	As soon as possible but no longer than 72

		Aetna	hours after getting assigned
Standard external review of experimental or investigational treatment adverse determination	Within 5 business days after receiving request to determine eligibility	Within 1 business day after the date of receiving request from Aetna	Within 20 days after the date it receives the opinion of each clinical peer to make a decision (clinical peers have 20 days to provide a written opinion to IRO)
Expedited review of experimental or investigational treatment adverse determination	Immediately after receiving request	Immediately after receiving request from Aetna	As soon as possible but no longer than 8 days after receipt of assignment The decision may take up to 8 days because the: • IRO has 1 day after receiving the request to assign the review to clinical review • Clinical peers shall provide an oral or written opinion to the IRO as soon as possible but no longer than 5 days of being assigned • IRO has 48 hours after the date it receives the opinion of each clinical peer to make a decision

*You will be sent a written notice, if your request is considered:

- Incomplete because of missing information. This notice will include what information or materials are needed to complete your request.
- Not eligible for the external review. This notice will include the reasons why it is not eligible.

Also, you have the right to have the adverse determination reviewed by the Louisiana Department of Insurance.

Utilization review

Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your **provider** or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We will pay fees or expenses incurred by us for sending information to the IRO and the cost of the external review.

The following has been added to or replaced in the *General provisions – other things you should know* section of your booklet-certificate:

When you are injured

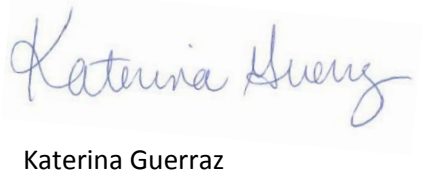
If someone else caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money. We are entitled to some of that money, up to the amount we paid for your care. We have that right no matter who is at fault or who the money comes from – for example, the other driver, the policyholder, or another insurance company.

To help us get paid back, you are doing these things now:

- Agreeing to repay us from money you receive because of your injury.
- Giving us the right to seek money in your name, from any person who causes you injury and from your own insurance. We can seek money only up to the amount we paid for your care.
- Agreeing to cooperate with us so we can get paid back in full. For example, you'll tell us within 30 days of when you seek money for your injury or illness. You'll hold any money you receive until we are paid in full. And you'll give us the right to money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

After you have been paid in full defined by any law that applies, we ask that you repay us for the care we gave because of your injury or illness. We will share in the cost for your lawyer, claim, or lawsuit as long as we are repaid for the amount we paid for your care. When we don't receive your help, we don't have to reduce the amount we're due for any reason, even to pay other costs you have for your recovery.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

Amendment: Louisiana ET Rider
Issue Date: February 20, 2025

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: El Camino Hospital

Group policy number: GP-0181066

Amendment effective date: January 1, 2025

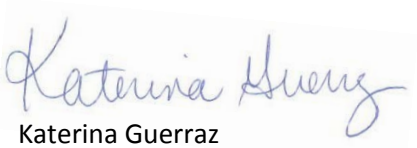
This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Michigan. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Elective Abortions

Elective abortions are only eligible for coverage if the procedure is necessary to preserve the life of the mother.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

Amendment: Michigan Medical ET
Issue Date: February 20, 2025

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: El Camino Hospital

Group policy number: GP-0181066

Amendment effective date: January 1, 2025

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Oregon. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Hearing aids and hearing assistive technology systems

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments, or accessories

Hearing assistive technology means:

- Devices used to improve your ability with hearing loss in situations such as:
  - Being located a distance from a speaker,
  - In an environment with competing background noise
  - In a room with poor acoustics or reverberation.

Covered services include prescribed hearing aids, hearing assistive technology systems and the following hearing aid services:

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who:
    - is legally qualified in audiology
    - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Bone conduction sound processors
- Any other related services necessary to access, select, and adjust or fit a hearing aid

A hearing aid maximum of one per ear every 36 months applies.

The following are not **covered services**:

- Replacement of a hearing aid that is lost, stolen or broken
- Replacement parts or repairs for a hearing aid
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

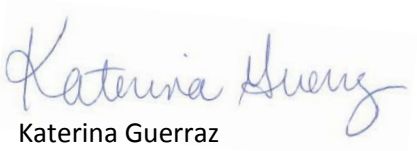
The following has been added to or replaced in the *Eligibility, Starting and Stopping Coverage* section of your booklet-certificate.

Domestic Partners

If your plan includes coverage for dependents, you can also enroll the following family members on your plan.

- Your domestic partner and their dependent children who meet the rules set by the **policyholder** and requirements under Oregon state law

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

Amendment: Oregon Medical ET
Issue Date: February 20, 2025

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: El Camino Hospital

Group policy number: GP-0181066

Amendment effective date: January 1, 2025

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Texas. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

The following has been added to or replaced in the *Preface* section of your booklet-certificate.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Aetna, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Aetna's toll-free telephone number at 1-888-416-2277
Toll-free: 1-888-416-2277
Online: www.aetna.com
Email: aetnamemberservices@aetna.com
Mail: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Aetna, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: al numero de teléfono gratis de Aetna al 1-888-416-2277
Teléfono gratuito: 1-888-416-2277
En línea: www.aetna.com
Correo electrónico: aetnamemberservices@aetna.com
Dirección postal: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Exclusive Provider Disclosure Notice

- An exclusive **provider** benefit plan provides no benefits for services you receive from **out-of-network providers**, with specific exceptions as described in your policy and below.

- You have the right to an adequate network of preferred **providers** (known as "network providers").
  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

- If your insurer approves a referral for out-of-network services because no preferred **provider** is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the non-preferred **provider's** bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.

- You may obtain a current **directory** of preferred **providers** at the following website: www.aetna.com or by calling **Aetna** Member Services at the toll-free number on your ID card for assistance in finding available preferred **providers**. If you relied on materially inaccurate **directory** information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

The insurance policy under which this certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system.

Underwritten by Aetna Life Insurance Company

The following content is added or replaced in the *Coverage and Exclusions* section of your booklet-certificate:

Autism spectrum disorder

Autism spectrum disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder – not otherwise specified.

Covered services include the "generally recognized services" provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder.

We will cover screenings of your dependent children for autism spectrum disorder. This is done at ages 18 months and 24 months.

Treatment for autism spectrum disorder is covered from the date of diagnosis.

We will cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan. You can receive treatment from a **provider** that meets at least one of the following criteria:

- Is licensed, certified or registered by an appropriate agency of Texas
- Has professional credentials that are recognized and accepted by an appropriate agency of the United States.
- Is certified as a **provider** under the TRICARE military health system.

You can also receive treatment from someone working under the supervision of a **provider** as described above. As used here, "generally recognized services" can include:

- Evaluation and assessment services
- Applied behavior analysis
- Behavior training and behavior management
- Speech therapy
- Physical therapy
- Occupational therapy
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder

Behavioral health

Mental health treatment

Covered services include the treatment of **mental health disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician,** or **behavioral health provider** including:

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility.**
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, **crisis stabilization unit**, residential treatment center for children and adolescents, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** or **telehealth** consultation)
  - Individual, group, and family therapies for the treatment of **mental health disorders**
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**

- Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  - Your **physician** orders them
  - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist (including **telemedicine** or **telehealth** consultation)

Covered services will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.

Substance related disorders treatment

Covered services include the treatment of **substance related disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician**, or **behavioral health provider** as follows:

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** or **telehealth** consultation)
  - Individual, group, and family therapies for the treatment of **substance related disorders**
  - Other outpatient **substance related disorders** treatment such as:
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist (including **telemedicine** or **telehealth** consultation)

Covered services will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.

Behavioral health important note:
The plan will not impose quantitative or nonquantitative treatment limitations on benefits for **mental health disorders** or **substance related disorders** that are generally more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

Behavioral health important note:
A peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a **behavioral health provider**.

Cardiovascular disease testing

Covered services include certain lab tests for the early detection of cardiovascular disease when a covered person has:

- Diabetes
- An intermediate or higher risk of getting coronary heart disease based on Framingham Heart Study prediction algorithms

The following lab tests may be done to screen for hardening and abnormal artery structure and function:

- Computed tomography (CT) scanning
- Ultrasonography

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in a phase I, phase II, phase III or phase IV approved clinical trial as a qualified individual for the prevention, detection, or treatment of cancer or other life-threatening disease or condition, as defined in the federal Public Health Service Act, Section 2709. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy
    - The Food and Drug Administration
    - An institutional review board of a Texas institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services
- The study or investigation is a drug trail that is exempt from having such an investigational new drug application

Coverage is limited to benefits for routine patient services provided within the network.

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an "approved clinical trial" only when you have cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- Your **provider** determines, and we agree, that based on published, peer-reviewed scientific evidence you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by the institutional review board of a Texas institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

Dental care services and anesthesia in a hospital or surgery center

Covered services include anesthesia and facility costs for dental care. Your **provider** must certify that the dental care cannot be performed in the dentist's office due to a physical, mental, or medical condition.

The following are not **covered services**:

- The related dental services unless specifically listed as a **covered service** in this certificate.

Diabetic services, supplies, equipment, and self-care programs

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Insulin and insulin analog preparation
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Injection devices including syringes, needles and pens
  - Injection aids, including devices used to assist with insulin injection and needleless systems
  - Diabetic test agents, including but not limited to, visual reading and test strips (blood glucose, ketone and urine)
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
  - Injectable glucagon's

  - Glucagon emergency kit
  - Biohazard disposal containers
- Equipment
  - External and implantable insulin pumps and pump supplies
    - Repairs and necessary maintenance of insulin pumps if not covered by manufacturer's warranty or purchase agreement
    - Rental fees for pumps during repair and maintenance
  - Blood glucose monitors without special features, unless required due to blindness
  - Podiatric appliances, including therapeutic shoes to prevent complications of diabetes
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

Covered services also include new or improved diabetic treatment, equipment and supplies that become available. They must be:

- Approved by the United States Food and Drug Administration
- Prescribed by your **provider**
- Sent to us in writing by your **provider**

All supplies, including medications and equipment for diabetes will be dispensed as written, and are not subject to preauthorization or step therapy requirements.

Diagnostic follow-up care related to newborn hearing screening

Covered services include necessary diagnostic follow-up care related to the newborn hearing screening test from birth through 24 months of age.

Important note:
Your cost share for diagnostic imaging using mammography, ultrasound imaging, or magnetic resonance imaging will be the same as mammograms performed for routine cancer screenings as described in the Preventive Care section when it is used to evaluate a breast abnormality detected by a **physician** or patient, or where there is a personal history of breast cancer or dense breast tissue.

This diagnostic imaging is not subject to any age limitations.

Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room. You can get **emergency services** from network or **out-of-network providers**.

The types of services that are eligible for coverage include:

- A medical screening examination or other evaluation required by state or federal law and provided to covered enrollees in a **hospital** emergency facility, freestanding emergency care facility or comparable facility, necessary to determine if an **emergency medical condition** exists.
- Treatment to stabilize your condition.
- Care in an emergency facility, freestanding emergency care facility or comparable facility after you become stable. But only if the treating **provider** asks us, and we approve the service. We will approve or deny the request within an hour after receiving the request.

When you are treated by an **out-of-network provider** when a **network provider** is not reasonably available or for an **emergency medical condition**, we will reimburse the **out-of-network provider** at the usual and customary rate or at an agreed rate. Please contact us if you receive a bill from the **out-of-network provider**. We will work to resolve the outstanding balance so that all you pay is the appropriate **network deductible**, **coinsurance**, or **copayments** under your plan.

You will be credited for:

- Any amounts due to you that would have been paid if the **provider** were a **network provider**
- Any out-of-pocket amounts that you paid to the **provider**, in excess of the allowed amount. Such amounts will be credited to your Calendar Year **deductible** amount and plan **coinsurance** limits, as applicable

Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan based on the usual and customary rate or at an agreed rate. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.

Your coverage for **emergency services** will continue until the following conditions are met:

- You are evaluated and your condition is stabilized
- Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** if you need more care

If your **physician** decides you need to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. See the *How your plan works – Medical necessity and preauthorization requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your **network physician** or **primary care physician** (**PCP**).

Non-emergency services

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits for more information.

Hearing aids, cochlear implants and related services

Covered services include hearing aids or cochlear implants and the following related services and supplies:

- Fitting and dispensing services and ear molds necessary to maintain optimal fit of hearing aids
- Treatment related to hearing aids and cochlear implants, including:
  - Habilitation and rehabilitation necessary for educational gain
  - For cochlear implants, an external speech processor and controller
- Internal replacement of cochlear implants as **medically necessary** or audiologically necessary

Covered services include prescribed hearing aids and the following hearing aid services:

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who:
    - Is legally qualified in audiology
    - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements

    - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not **covered services**:
- Replacement of a hearing aid that is lost, stolen or broken
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Home health care

Covered services include home health care provided by a **home health care agency** in the home, but only when all of the following criteria are met:
- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**
- The services are a part of a home health care plan
- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

Short-term physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See *Rehabilitation services* and *Habilitation therapy services* in this section and the schedule of benefits.

The following are not **covered services**:
- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services, including care and services for complications of pregnancy.

Complications of pregnancy are:
- Conditions requiring **hospital** confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as:
    - Acute nephritis
    - Nephrosis
    - Cardiac decompensation
    - Missed abortion
    - Similar medical and surgical conditions of comparable severity
- The following conditions that occur during a period of gestation in which a viable birth is not possible:
    - Non-elective cesarean section

- Termination of ectopic pregnancy
- Spontaneous termination of pregnancy

Complications of pregnancy do not include:

- False labor
- Occasional spotting
- Physician prescribed rest during the period of pregnancy
- Morning sickness
- Hyperemesis gravidarum
- Pre-eclampsia
- Similar conditions associated with the management of a difficult pregnancy not constitution a nosologically distinct complication of pregnancy.

Services and supplies for complications of pregnancy will be covered the same as any other illness or injury.

After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **health care facility** after a vaginal delivery
- No less than 96 hours of inpatient care in a **health care facility** after a cesarean delivery
  A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

If the mother is discharged earlier, the plan will pay for home visits after delivery by a health care **provider**.

These time frames apply if your child is born without any problem. If your **provider** tells us that you had a problem during your pregnancy or during childbirth, we will cover the **stay** the same as we would for any other illness or injury.

Covered services for newborn care include:

- Services and supplies needed for circumcision by a **provider**
- Treatment of congenital defects. These services will be covered the same as any other illness or injury

The following are not **covered services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Nutritional support

For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino acid based elemental formula.

We will cover these items to the same extent that the plan covers drugs that are available only on the orders of a physician.

The following are not **covered services**:
Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- Medical foods
- Other nutritional items

Orthotic devices

Covered services include the initial orthotic device and subsequent replacement that your **physician** orders and administers.

We will cover the same type devices that are covered by Medicare. Your **provider** will tell us which device best fits your need. But we cover it only if we **preauthorize** the device.

Orthotic device means a customized medical device applied to a part of the body to:

- Correct a deformity
- Improve function
- Relieve symptoms of a disease

Coverage Includes:

- Repairing or replacing the original device. Examples of these are:
  - Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
  - Replacements required by ordinary wear and tear or damage
- Instruction and other services (such as attachment or insertion) so you can properly use the device.

The following are not **covered services:**

- Services covered under any other benefit
- Repair and replacement due to loss, misuse, abuse or theft

Osteoporosis

Covered services include services to detect and prevent osteoporosis for:

- A postmenopausal woman not receiving estrogen replacement therapy
- An individual with:
  - Vertebral abnormalities
  - Primary hyperparathyroidism
  - A history of bone fractures
- An individual who is:
  - Receiving long-term glucocorticoid therapy
  - Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

Physician services

Covered services include services by your **physician** to treat an illness or injury. You can get services:

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine, teledentistry** or **telehealth**

Important note:
For behavioral health services, all in-person, **covered services** with a **behavioral health provider** are also **covered services** if you use **telemedicine** or **telehealth** instead.

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

The Types of services that require preauthorization section is revised as follows:

A **preauthorization** may not be required for some services if your **provider** meets the requirements of prior **preauthorization** approvals. Please contact your **physician** or us for additional information.

Your **provider** may request a renewal of an existing **preauthorization** within 60 days of the expiration date of the preauthorization. We will notify you of our decision before the expiration of the existing **preauthorization**.

The following has been added to or replaced in the *Preventive care* section of your certificate

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, a pathology exam on any removed polyp, or a follow-up colonoscopy if the findings are abnormal
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms (All forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

The following has been added to or replaced in the *Preventive care* section of your schedule of benefits

Preventive care

Description	In-network
Preventive care services	100% per visit, no **deductible** applies
Breast feeding counseling and support	100% per visit, no **deductible** applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/12 months
Family planning services (contraception, counseling)	100% per visit, no **deductible** applies
Family planning services (contraception, counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	100%, no **deductible** applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine cancer screenings	100% per visit, no **deductible** applies
Mammogram limits	One mammogram every year for covered persons age 35 and older.

	When diagnostic imaging is used to evaluate a breast abnormality or where there is a personal history of breast cancer or dense breast tissue it is not subject to any age or frequency limitations.
Prostate specific antigen (PSA) test limits	One PSA test every year for covered persons age 45 and over One PSA test every year for covered persons age 40 and older with a family history of prostate cancer, or other risk factor
Additional routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening	100% per visit, no **deductible** applies
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no **deductible** applies
Pap smear or screening using liquid based cytology methods	One pap smear every 12 months for women age 18 or older
Gynecological exam that includes a rectovaginal pelvic exam	One exam every 12 months for women over age 25 who are at risk for ovarian cancer
Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test	One exam every 12 months for women age 18 and older
Additional well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
Limit	1 visit

Prosthetic device

A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

We will cover the same type devices covered by Medicare. Your **provider** will tell us which device best fits your needs.

Coverage includes:

- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage

If you receive a prosthetic device as part of another **covered service** and therefore it will not be covered under this benefit.

The following are not **covered services**:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses
- Unless you or your **physician** decide that a shorter time period for inpatient care is appropriate, **covered services** for reconstructive breast **surgery** include:
  - 96 hours of inpatient care following a mastectomy
  - 48 hours of inpatient care in a network health care facility after lymph node dissection for treatment of breast cancer

Reconstructive surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

- Your **surgery** corrects a craniofacial abnormality. This includes an abnormal structure that is caused by developmental deformities, congenital defects, trauma, tumors, infections or disease. The **surgery** will be covered if:
    - The purpose of the **surgery** is to improve function or attempt to create a normal appearance.

Covered services also include the procedures or **surgery** to sound natural teeth**,** injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

Inpatient and outpatient treatment for acquired brain injury

Covered services include treatment for an acquired brain injury. An acquired brain injury does not include a congenital or degenerative illness or injury. It means a neurological injury to the brain, after birth, that results in loss of:

- Physical function
- Sensory processing
- Cognition
- Psychological behavior

The therapy is coordinated with us as part of a treatment plan intended to:

- Maintain or restore previous cognitive function
- Slow further loss of function

Covered services include the following therapies related to an acquired brain injury:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment.
- Neurofeedback therapy
- Remediation
- Post-acute transition services
- Community reintegration services
- Post-acute care treatment due to, and related to, an acquired brain injury**.** If you have been unresponsive to treatment, this also includes checking from time to time to see if you become responsive.

Covered services also include care in an assisted living facility that is:

- Within scope of their license, and
- Within scope of the services provided under an accredited rehabilitation program for brain injury**.**

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

The following content is added or replaced in the *Coverage and Exclusions* and *Glossary* section of your certificate:

Telemedicine, teledentistry or telehealth

Covered services include **telemedicine, teledentistry** or **telehealth** consultations when provided by a **physician**, **specialist, behavioral health provider** or other **telemedicine** or **telehealth provider** acting within the scope of their license.

Covered services for **telemedicine, teledentistry** or **telehealth** consultations are available from a number of different kinds of **providers** under your plan. Log in to your member website at https://www.aetna.com/ to review our **telemedicine, teledentistry** or **telehealth provider** listing and Contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

- Telephone calls
- **Telemedicine** or **telehealth** kiosks
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Teledentistry

A health care service delivered by a dentist, or a **health professional** acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or **health professional's** license or certification to a patient at a different physical location than the dentist or **health professional** using telecommunications or information technology.

Therapies – chemotherapy

Chemotherapy

Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Covered services also include anti-cancer **prescription drugs** for chemotherapy. Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer medication covered as a medical benefit rather than as a **prescription drug** benefit. Also, the cost-sharing for anti-cancer prescription drugs will not exceed the **coinsurance** or **copayment** applicable to a chemotherapy visit or cancer treatment visit. Your prescriber or your pharmacist may need to get approval from us before we will agree to cover the drug for you. See the *Preauthorization* section for details.

The following content is added or replaced in the *How your plan pays* section of your booklet-certificate:

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network
- You are already an Aetna member and your **provider** stops being in our network

However, in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

	If you are a new enrollee and your provider is out of network provider	**When your provider stops participation with Aetna**
Request for approval	You need to complete a transition of coverage request form and send it to us. You can get this form by contacting us.	You or your **provider** should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period for up to 90 days. This date is based on the date the **provider** terminated their participation with us.
How claim is paid	Your claim will be paid at the **network** cost sharing level during the transitional period.	Your claim will be paid at the **network** cost sharing level during the transitional period.

	If you have a terminal illness and your provider stops participation with us
Request for approval	Your **provider** should call us for approval to continue any care. You can call us for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to 9 months. This date is based on the date the **provider** terminated their participation with us.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

	If you are pregnant and have entered your second trimester and your provider stops participation with Aetna
Request for approval	Your **provider** should call us for approval to continue any care. You can call us for information on continuity of care.
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to delivery. This includes a post-delivery checkup within six weeks.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

If this situation applies to you, contact us for details. If we approve your request to keep going to your current **provider**, we will tell you how long you can continue to see the **provider**. If you are pregnant and have initiated a course of prenatal care, regardless of the trimester care was initiated, this will include the time required for postpartum care directly related to the delivery.

We will authorize coverage only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

NOTICE: “ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN UNLESS BALANCE BILLING FOR THOSE SERVICES IS PROHIBITED."

Coordination of benefits

The Coordination of Benefits (“COB”) provision applies when a person has health care coverage under more than one health plan. If you do, we will work with your other plan to decide how much each plan pays. This is called coordination of benefits (COB). A plan is defined below under Key terms.

Order of benefit determination rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

• The primary plan pays according to its terms of coverage and without regard to the benefits under any other plan
• A plan does not have a COB provision is always primary unless the provisions of both plans state that the complying plan is primary, except: - Coverage that you have because of membership in a group that is designed to supplement part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are: o Major medical coverages that are superimposed over base plan **hospital** and **surgical** benefits o Insurance type coverages that are written in connection with a closed panel to provide **out-of-network** benefits.
• A plan may consider the benefits paid by another plan in calculating payment of its benefits only when it is secondary to that other plan.
• If the primary plan is closed panel plan and the secondary plan is not, the secondary plan must pay benefits as if it were the primary plan when a covered person uses an **out-of-network provider** or **physician** except for **emergency services** or authorized **referrals** that are paid or provided by the primary plan.
• When multiple contracts providing coordinated coverage are treated as a single plan, this applies only to the plan as a whole. Coordination among the component contract is governed by the terms of the contracts. If more than one carrier pays or provided benefits under the plan, the carrier designated ad primary within the plan must be responsible for the plan’s compliance with these rules.
• If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans’ benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of the secondary plan.

Key Terms

Here are some key terms we use in this section. These will help you understand this COB section.

Plan:

A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

• A plan includes:	• Group blanket or franchise accident and health insurance policies, excluding disability income protection coverage • Individual and group health maintenance organization evidences of coverage • Individual accident and health insurance policies • Individual and group preferred provider benefit plans and exclusive provider benefit plans • Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care • Medical care components of individual and group long-term care contracts • Limited benefit coverage that is not issued to supplement individual or group in-force policies • Uninsured arrangements of group or group-type coverage • The medical benefits coverage in automobile insurance contracts • Medicare or other governmental benefits as permitted by law
• A plan does not include:	• Disability income protection coverage • The Texas Health Insurance Pool • Workers' compensation insurance coverage • **Hospital** confinement indemnity coverage or other fixed indemnity coverage • Specified disease coverage • Supplemental benefit coverage • Specified accident coverage • School accident-type coverages that cover students for accidents only, including athletic injuries, either on "24-hour" or a "to and from school" basis • Benefits provided in Long-term care insurance contracts for non-medical services, for example, personal care,

	adult day care, homemaker services, assistance with activities of daily living, respite care, and **custodial care** or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services • Medicare supplement policies • A state plan under Medicaid • A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan • Other nongovernmental plan • An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable **deductible**

Each plan for coverage is a separate plan, If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan

This plan:
This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans

• How this plan coordinates with like benefits:	Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.
• The order of benefit determination rules for this plan:	The order of benefit determination rules determines whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. • When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits • When this plan is secondary, it determines its benefits after those of another plan an may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense

Allowable expense:
Allowable expense is a health, medical eye care, vision, or dental care expense, including **deductibles,** coinsurance and **copayments**, that is covered at least in part by any plan covering the person.

• Allowable expense for benefits provided in the form of services:	When a plan provides benefits in the form of services the reasonable cash value of each service will be considered an allowable expense and a benefit paid.
• Expenses that are not allowable expenses:	An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a **provider** or **physician** by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense. Some expenses and services are not allowable expenses. Here are some examples: • The difference between the cost of a semi-private **hospital** room and a private **hospital** room is not an allowable expense, unless one of the plans provides coverage for private **hospital** room expenses. • If a person is covered by two or more plans that don't have a **negotiated charge** and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for specific benefit is not an allowable expense. • If a person is covered by two or more plans that provide benefits or services on the basis of **negotiated charges,** an amount in excess of the highest of the **negotiated charges** is not an allowable expense. • If a person is covered by one plan that does not have **negotiated charges** and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides it benefits or services based on **negotiated charges**, the primary plan's payment arrangement must be the allowable expense for all

	plans. However, if the health care **provider** or **physician** has contracted with the secondary plan to provide the benefit or service for a specific **negotiated charge** or payment amount that is different that the primary plan's payment arrangement and if the health care **provider** or **physician** contract permits, the **negotiated charge** or payment must be the allowable expense used by the secondary plan to determine its benefits. • The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, **preauthorization** of admissions, and **network provider** and **physician** arrangements.

Allowed amount:
Allowed amount is the amount of a billed charge that a carrier determines to be covered for services by an **out-of-network provider.** The amount includes both the carrier's payment and any applicable **deductible, copayment,** or **coinsurance** amounts for which the insured is responsible.

Closed panel plan:
Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care **providers** and **physicians** that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care **providers** and **physicians**, except in cases of emergency or referral by a panel member.

Custodial parent:
Custodial parent is the parent with the right to designate the primary residence of a child by court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information. A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary Plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, policyholder, retired employee or subscriber (not as a dependent) If you or your spouse have Medicare coverage, this may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. If you have any questions about this you can contact us.	Plan covering you as a dependent If you or your spouse have Medicare coverage, this may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. If you have any questions about this you can contact us.
Child – parents married or living together, whether or not they have ever been married	Plan of parent whose birthday (month and day) is earlier in the calendar year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together, whether or not they have ever been married	• Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent's plan if there is no court order	• Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent's plan
Child – covered by individuals who are not his or her parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Child of: Persons who are not his or her parents	The rules shown for parents will apply, as if the persons were parents of the child	The rules shown for parents will apply, as if the persons were parents of the child
Child of: Parents, who is also covered under a spouses plan	The plan has covered the person longer is primary If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.	The plan has covered the person longer is primary If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.

Active or inactive employee This rule does not apply if: • The plan that covers you as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits • The "Non-dependent or Dependent" paragraph, above can determine the order of benefits	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation This rule does not apply if: • The other plan does not have the rule, and as a result, the plans do not agree on the order of benefits • The "Non-dependent or Dependent" paragraph, above can determine the order of benefits	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally This plan will not pay more than it would have paid had it been the primary plan.	Plans share expenses equally This plan will not pay more than it would have paid had it been the primary plan.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

Effect on the benefits of this plan

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan:
  - Will calculate the benefits it would have paid in the absence of other health care coverage. The calculated amount will be applied to any allowable expense under its plan that is unpaid

by the primary plan.
    - May reduce its payment so that the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim.
    - Must credit to its plan **deductible** any amounts it would have credited to its **deductible** in the absence of other health care coverage.
- If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel **provider**, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with federal and state laws concerning confidential information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid. Or, we may recover from any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of the benefits provided in the form of services.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

Recovery rights related to workers' compensation

If we pay more than we should have because workers' compensation benefits paid for the same illness or injury we may recover the excess from any of the following:

- Any person we paid or for whom we paid
- Any workers' compensation plan that is responsible for payment
- Any fund designed to provide benefits for workers' compensation claims

The recovery rights will be applied even if:

- The benefits are in dispute or are paid by means of settlement or compromise
- No decision has been made that the illness or injury was in the course of, or due to, your employment
- No agreement has been made by you, or the workers' compensation plan, about the amount of benefits due to health care
- The health care benefits are excluded from the workers' compensation settlement or compromise

By accepting benefits under this plan, you or your representatives agree to:

- Notify us of any workers' compensation claim made
- Reimburse us as described

Our rights

We have the right to:

- Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
- Reimburse another health plan that paid a benefit we should have paid
- Recover any excess payment from a person or another health plan, if we paid more than we should have paid

The following content is added or replaced in the *Complaints, claim decisions and appeal procedures* section of your booklet-certificate:

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

A complaint is any oral or written expression of dissatisfaction regarding any aspect of our operation. You, someone who represents you, or your provider may file the complaint. You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

It is not a complaint if:

- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your **provider** call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determination* sections for more information

Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know that we have received your complaint within 5 business days. Our letter will tell you about our complaint procedures and timeframes. If you call us to complain, we will send you a complaint form to complete and return

If your complaint concerns an emergency, or denial of continued hospitalization or **prescription drugs** and intravenous infusions, we will do an expedited appeal review. See the *Appeal of adverse determination*s and *Timeframes for deciding appeals of adverse determinations* sections for more information.

Adverse determinations

An adverse determination is our determination that the health care services you have received, or may receive are:

- **Experimental or investigational**
- Not **medically necessary**

If we deny health care services because your **provider** does not request **preauthorization** or a concurrent claim extension, it is not an adverse determination.

If we make an adverse determination, we will tell you in writing. Our written decision will tell you:

- The main reason for denial
- The clinical reason for denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including your right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves:
  - A life threatening condition

- The provision of **prescription drugs** or intravenous infusions for which the patient is receiving health benefits under the policy
- Requests for **step therapy** exception

The chart below shows how much time we have to tell you about an adverse determination.

Type of notice	When you need care to make sure you are stable following emergency treatment (post-stabilization)	While you are in the hospital	When not hospitalized at the time of the decision	**Prescription drugs** or other intravenous infusions that you are currently receiving	Retrospective
Initial decision	No later than 1 hour after the request to the treating **provider**	Within 1 business day by phone or email to your **provider** followed by written notice within 3 business days to you and your **provider**	Within 3 business days to you and your provider	No later than 30th day before on which the **prescription drugs** or intravenous infusions will be discontinued	Within 30 days after the date on which the claim is received
Extensions	Not applicable	Not applicable	Not applicable	Not applicable	15 days
Additional Information Request (us)	Not applicable	Not applicable	Not applicable	Not applicable	30 days
Response to additional information request (you)	Not applicable	Not applicable	Not applicable	Not applicable	45 days

Important note:
We will tell you about an adverse determination within the time appropriate to the circumstances relating to the delivery of the services and your condition. We will always tell no later than the times shown in the chart above.

Appeal
Your request to reconsider an adverse determination is an appeal of an adverse determination. It is also an appeal if you ask us to re-review a complaint because you are not happy with our initial response. The *Appeal of a complain*t and *Appeal of adverse determinations* sections below explain the appeal.

Claim decisions and appeal procedures

Your **provider** may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in *Benefit payments and claims* in the *How your plan works* section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an "adverse determination" or "adverse decision." For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse determination. This is the internal appeal process. If you still don't agree, you can also appeal that decision.

Appeal of a complaint

You can ask us to re-review your complaint. You can appeal by contacting us.

We will let you know that we have received your appeal within 5 business days. This notice will describe the appeals process and your rights. Part of this process is that we will assign a panel to review your appeal. You will have the opportunity to provide additional information for the panel to consider in the review your appeal. You or an authorized representative can attend the appeal hearing in person or by telephone.

The panel will include an equal number of:

- Non-employee members.
- Texas Health Aetna representatives who were not involved in making the initial decision.
- **Providers** (including **specialists**) who were not involved in making the decision. We will us a **provider** with experience in the area of care that is disputed.

We will send you the following information at least 5 days before the appeal panel hearing, unless you agree otherwise:

- A copy of any documentation to be presented by our staff
- The specialties of the **physician** or **providers** consulted during the review
- The name and affiliation of all Texas Health Aetna representatives on the appeal panel

You may respond to this information. The appeal panel will consider your response in their review.

The panel will review the information and provide us with their decision. We will send you the final decision in writing within 30 calendar days of receiving the appeal. If your appeal is for services that you have not already received, we will send you the final decision in writing within 15 calendar days of receiving the appeal. The letter will include:

- The date we received the appeal request
- The panel's understanding of your complaint and the facts
- The clinical basis and criteria used to make the decision
- Documents supporting the decision
- If applicable, a statement of your right to request an independent review
- A statement of your right to appeal to the department of insurance at:

  Texas Department of Insurance
  P.O. Box 149104

Austin, TX 78714-9104
1-800-252-3439

If you ask, we will give you or your representative reasonable access to appeal information. This includes all documents, records and other information we used to decide the claim, or appeal. We will not charge you for the information.

Appeal of an adverse determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form.

Any other claim appeal

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse determination.

You can appeal by sending a written appeal to the address on the notice of adverse determination, or by contacting us. You need to include:

- Your name
- The policyholder's name
- A copy of the adverse determination
- Your reasons for making the appeal
- Any other information you would like us to consider

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

We will let you know that we have received your appeal of the adverse determination within 5 business days. This notice will describe the appeals process and your rights. If you call us to appeal, we will send you an appeal form to complete and return.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse decision.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse determination. You can respond to the information before we tell you what our final decision is.

Expedited internal appeal

You are entitled to an expedited internal appeal process for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays in a **hospital**. You can also ask for an expedited internal appeal if we deny a request for **step therapy** exception or a request for **prescription drugs** or intravenous infusions you are currently receiving.

Important note:
You can skip our standard and expedited internal appeal process and instead appeal to an independent review organization (IRO) in some situations. See the *Exhaustion of appeals process* section.

Timeframes for deciding appeals of adverse determination

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision. We may tell you about our decision orally or in writing. If we tell you orally, we will send you a letter within 3 calendar days after the oral notice.

Type of claim	**Our response time from receipt of appeal**
Urgent care claim	As soon as possible (based on the medical urgency of the case) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received
Emergency medical condition	As soon as possible but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received
When you need care to make sure you are stable following emergency treatment (post-stabilization)	No later than 1 hour after the request
If you are hospitalized at the time of the adverse determination (may include concurrent care claim of **hospital** stays)	No later than 1 business day from the date all information to complete the review is received*
If you are receiving **prescription drugs** or intravenous infusions	As soon as possible but no later than 1 business day from the date all information to complete the review is received*
Pre-service claim requiring **preauthorization**	As soon as possible but no later than 15 calendar days*
Requests for **step-therapy** exception (non-emergency)	No later than 72 hours after we receive the request
Requests for step-therapy exception (emergency)	No later than 24 hours after we receive the request
Acquired brain injury	No later than 3 business after the request
Retrospective claim	As soon as possible, but no later than 30 calendar days from receipt of the request for appeal*
Expedited internal appeal	As soon as possible (based on the medical or dental immediacy of the condition, procedure, or treatment under review) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received

*If your appeal is denied, your **provider** may ask us in writing to have a certain type of specialty **provider** review your case. The request must be made no later than 10 business days after the appeal was denied. A **provider** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

Exhaustion of appeal process

In most situations, you must complete an appeal with us before you can appeal through an external review process.

We encourage you to complete an appeal with us before you pursue voluntary arbitration, litigation or other type of administrative proceeding.

Sometimes you do not have to complete the appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the independent review process at the same time.
- We did not follow all of the claim determination and appeal requirements of the Texas and the federal Department of Health and Human Services. But you will not be able to proceed directly to independent review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us
- You have a life-threatening condition. You can have your appeal reviewed through the independent review process.
- If you are receiving **prescription drugs** or intravenous infusion treatment and we deny them. You can have your appeal reviewed through the independent review process.
- Your request for a **step therapy** exception was denied. You can have your appeal reviewed through the independent review process.

Independent review

Independent review is a review done by people in an organization outside of Texas Health Aetna. This is called an independent review organization (IRO).

You have a right to independent review only if all the following conditions are met:

- You have received an adverse determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate
- We decided the service or supply is **experimental or investigational**

If our claim decision is one for which you can seek independent review, we will say that in the notice of adverse determination we send you. That notice also will describe the independent review process. It will include a copy of the request for independent review form.

You must submit the request for independent review form:

- To Texas Health Aetna
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

You will pay for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

Texas Health Aetna will contact the IRO that will conduct the review of your claim. If your request is based on exigent circumstances your request will be sent as soon as possible. An “exigent circumstance means when you are:

- Experiencing a health condition that may seriously jeopardize your life, health or ability to regain maximum function
- Undergoing a current course of treatment using a non-formulary drug

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the IRO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IRO decision?

We will give you the IRO decision not more than 45 calendar days after we receive your notice of independent review form with all the information you need to send in.

Sometimes you can get a faster independent review decision. Your **provider** must call us or send us a request for independent review form.

You may be able to get a faster independent review after an adverse determination if:

- Your **provider** tells us that a delay in your receiving health care services would:
  - Jeopardize your life, health or ability to regain maximum function
  - Be much less effective if not started right away (**experimental or investigational** treatment)
- The adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request or within 24 hour if your request is for an exigent circumstance.

Utilization review

Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your **provider** or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal. But we will pay the fees or expenses incurred for the review of the IRO.

The following content is added or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate:

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets policyholder rules and requirements under state law
- Dependent children – yours or your spouse's or partner's
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including any children placed with you for adoption*
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Grandchildren in your legal custody
    - Grandchild who is your dependent for federal tax purposes at the time application for coverage of the grandchild is made

  *Your adopted child may be enrolled as shown in the *When you can join the plan* section, after the date:

    - You become a party in a suit for adoption, or
    - The adoption becomes final

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth:
  - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information. Or, you can call to notify us. You must provide the information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- Adoption or placement for adoption:
  - A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after you become a party in a suit for adoption or the adoption is complete.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after you become a party in a suit for adoption or the adoption is complete.
  - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date.

Stopping coverage

Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the *Special coverage options after your coverage ends* section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The policyholder asks to end coverage
- You are no longer eligible for coverage
- Your work ends
- You stop making required premium contributions, if any apply
- We end your coverage for one of the reasons shown in this section
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage.
- You stop making premium contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
  - Exhaustion of your overall maximum benefit.

- You enroll under a group Medicare plan we offer.

Your employer will notify Aetna of the date your coverage ends. You and your dependents will be covered until the end of the month after we receive the notice, unless any of the following occur:

- Your employer notifies you at least 30 days before coverage ends
- You and your dependents are covered under COBRA or state continuation
- You and your dependents are enrolled in another health plan that starts before the end of the month after we receive the notice

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your coverage ends* section for more information.

Why would we end your coverage?

We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayment for periods after the date your coverage ended.

We will not end your coverage based on your health care status or needs, we also will not end your coverage because you used your rights under the *Complaints, claim decisions, and appeal procedures* section.

Continuation of coverage – State of Texas

Continuation privilege for certain dependents

There are events that may cause your dependents to lose coverage. For some events, certain dependents are eligible to continue their coverage for a time. Here are the events, eligible dependents and time periods:

Qualifying event causing loss of coverage:	**Covered persons eligible for continued coverage:**	**Length of continued coverage (starts from the day you lose current coverage):**
• Death of employee • Retirement of employee • Retirement of employee	• Dependent who has been covered under the plan for at least one year • An infant under one year of age	3 years

When do I receive state continuation information?

The chart below lists who must give notice, the type of notice required, and the time period to give the notice.

Notice	**Requirement**	**Deadline**
You or your covered spouse	Send written notice to your employer	Within 15 days of the qualifying event
Your employer	Will provide you with an enrollment form to continue coverage	No later than 15 days after they receive notification
You or your covered spouse	Complete the enrollment form	Within 60 days of the qualifying

	to continue coverage	event.

You must send the completed enrollment form from within 60 days of the qualifying event. If you don't, you will lose the right to continue coverage. We will cover your dependent during this period as long as the premiums and administrative charges are paid.

Group continuation privilege

You may continue coverage if your coverage ends for any reason except:

- Involuntary termination for cause
- Discontinuance of the group agreement

To continue coverage, you must be covered for at least 3 months in a row right before your coverage ends.

You must give your employer written election of continuation no more than 60 days following the later of the date:

- Your coverage ends or
- You are given notice by the contract holder

Your first premium payment must be made within 45 days after the date of the coverage election. After that, premium payments are due no later than the end of the grace period after the premium due date.

You can continue coverage until the earliest of:

- Six months after the end of the COBRA continuation period, if you are eligible for COBRA
- Nine months after the date election is made, if you are not eligible for COBRA
- The date you fail to pay premiums
- The date the group coverage terminates in its entirety
- The date you are covered for similar benefits by another health insurance policy or program
- The date you are covered (other than COBRA) for similar benefits by another plan

Continuation of coverage for other reasons

How you can extend coverage if you are totally disabled when coverage ends

Your coverage may be extended if you are totally disabled when coverage ends. You are "totally disabled" if you cannot perform all of the substantial and material duties and functions of your occupation and any other gainful occupation in which you earn substantially the same compensation you earned before the disability.

Your covered dependent is "totally disabled" if they can't engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

- When you or your dependent are no longer totally disabled
- When you become covered by another health benefits plan
- 12 months of coverage

The following content is added or replaced in the *General Provisions* section of your booklet-certificate:

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. Even **network providers** are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **preauthorization**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or **provider**, can do this. Any modifications made will be no less favorable than the current plan requirements.

Notice of claim

You must give us written notice of claim within 20 days (or as soon as reasonably possible) after you have incurred expenses for **covered services**. You can send the claim to us or to one of our authorized agents. We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. See the *Proof of loss* section below.

Physical examination and evaluations

At our expense, we have the right to have a **physician** of our choice examine you. This will be done at reasonable times while certification or a claim for benefits is pending or under review.

Proof of loss

You must submit written proof of loss you within 90 days after your loss occurs. If you couldn't reasonably provide this proof within 90 days, we will still accept your claim. But you must provide the proof as soon as possible, but no later than one year after the 90 days ends (unless you were legally incapacitated).

Time of payment of claims

We will pay benefits to you or your assignee. After we receive your timely proof of loss, we will pay claims within 60 days after we receive the proof of loss. Please see the *Proof of loss* section above.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:

- Names of **physicians** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years after the effective date of this certificate.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Rescission of coverage
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities. See the *Benefit payments and claims, Filing a claim* section for information about rescission.

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage
- You have the right to an Aetna appeal
- You have the right to a third party review conducted by an independent IRO

We won't rescind your coverage due to an intentional deception if the deception happened more than 2 years after the effective date of this certificate.

In the absence of fraud, any statement made on your application for coverage is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

Premium contribution

Your plan requires that the policyholder make premium contribution payments. We will not pay for benefits if premium contributions are not made by the end of the grace period. Any decision to not pay benefits can be appealed.

When you are injured by a third party

If a third party caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money for your injuries. If you have a legal right to get money from a third party for causing your injuries, we are entitled to that money, up to the amount we pay for your care.

When you have a legal right to get money from one or more third parties for causing your injuries and you pursue that legal right, you are:

- Agreeing to repay us from money you receive from those third parties because of your injury.
- Giving us the right to seek money in your name, from those third parties because of your injuries.

- Agreeing to cooperate with us so we can get paid back in full, up to the applicable amount noted below. For example, you'll tell us within 30 days of when you seek money from those third parties for your injury or illness. You'll hold any money you receive until we are paid in full. And you'll give us the right to our portion of the money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money. Notify us by contacting us.

We will only seek money from your own uninsured/underinsured motorist or medical payments coverage (if any) if you or your immediate family member did not pay premiums for the coverage.
If you are not represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive, or
- The total amount paid by us

If you are represented by an attorney, then we can recover the lessor of:

- One-half of the money you receive, less attorney's fees and costs for the recovery, or
- The total amount paid by us, less attorney's fees and costs for the recovery

How will Attorney's fees be determined?
If we do not use an attorney:

- We (and any other payors) will pay your attorney a fee agreed to between us (and other payors) and your attorney plus a pro rata share of the recovery expenses
- If no agreement exists, then the court will award your attorney a reasonable fee payable for our (and any other payors) share of the recovery not to exceed 1/3 of the recovery

If we use an attorney:

- The court will award attorney's fees to our attorney and your attorney based on the benefit accruing as a result of each attorney's service. The total attorney's fees may not exceed 1/3 of our (and any other payors) recovery.

Payor means a plan issuer that:

- Has a contractual right of subrogation, and
- Pays benefits to you or on your behalf as a result of personal injuries caused by someone else's tortious conduct

A payor includes, but is not limited to, an issuer of:

- A health benefit that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness
- A disability benefit plan
- An employee welfare benefit plan

Payment to a conservator, other than you

Sometimes a court order gives another person certain rights and duties to act on behalf of your dependent child. Such a person is called a managing or possessory conservator. We may pay that person benefits on behalf of your dependent child. To receive benefits, they must send us a written certified copy of the court order with the claim form. But they are not entitled to benefits if:

- We received a valid assignment of benefits on an unpaid medical bill
- You sent us a claim for benefits for **covered services** that you paid

Reimbursement to Texas Health and Human Services Commission

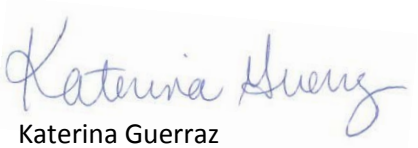
We will repay the actual costs of medical expenses the Texas Health and Human Services Commission pays through medical assistance for you or your dependent if you or your dependent are entitled to payment for the medical expenses.

Repayment of these medical expenses for your dependent child will be paid to the Texas Health and Human Services Commission if, when you submit proof of loss, you notify us in writing that:

- Your dependent child is covered under the financial and medical assistance service program in Texas and you either:
  - Have possession or access to the child through a court order; or
  - Are not entitled to possession of our access to the child and are required by the court to pay child support

You will need to ask us to make direct payment to the Texas Health and Human Services Commission.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

Amendment: Texas Medical ET
Issue Date: February 20, 2025

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: El Camino Hospital

Group policy number: GP-0181066

Amendment effective date: January 1, 2025

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Washington. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Abortion

Eligible health services include services and supplies for an abortion. This is the voluntary termination of pregnancy performed by a **health professional**.

Acupuncture

Eligible health services include acupuncture. The service performed must be within the scope of an East Asian Medicine Practitioner's license, as regulated by Washington state law.

Applied behavior analysis

Covered services include applied behavior analysis.
Applied behavior analysis is a process of applying interventions that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

Home health care

Eligible health services include home health care services and home dialysis services provided by a **home health care agency** in the home, but only when all of the following criteria are met:

- You are homebound
- Your **health professional** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home
- The services are a part of a **home health care plan**
- The services are skilled nursing services, home health aide services, palliative care services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse (**R.N.**)
- Medical social services are provided by or supervised by a **physician**, other **health professional**

or social worker

Short-term physical, speech and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home.

Home health care services do not include **custodial care**.

Exclusions

Your plan does not cover the following under this section:

- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care

Eligible health services include inpatient and outpatient **hospice care** when given as part of a **hospice care program**.

The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital**
- Bereavement counseling
- Respite care
- Palliative care

Hospice care services provided by the **providers** below may be covered, even if the **providers** are not an employee of the **hospice care agency** responsible for your care:

- A **physician** or other **health professional** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription drugs**
  - Psychological counseling
  - Dietary counseling
  - Palliative care

Exclusions

Your plan does not cover the following under this section:

- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Jaw joint disorder treatment

Eligible health services include the diagnosis and surgical treatment of **jaw joint disorder** by a **provider** which includes:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- Involving the relationship between the jaw joint and related muscles and nerves such as myofascial pain dysfunction (MPD)

The following are not covered under this benefit:

- Non-surgical treatment of **jaw joint disorder**

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Maternity and related newborn care

Covered services also include the inpatient use of **medically necessary** donor human milk obtained from a milk bank when prescribed by a licensed **health professional** for an infant who is medically or physically unable to receive maternal breast milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal breast milk in sufficient quantities or caloric density or participate in chest feeding. Such infant must meet at least one of the following criteria:

- Infant birth weight of less than 2,500 grams
- Infant gestational age equal to or less than 34 weeks
- Infant hypoglycemia
- A high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, or retinopathy of prematurity
- A congenital or acquired gastrointestinal condition with long-term feeding or malabsorption complications
- Congenital heart disease requiring surgery in the first year of life
- An organ or bone marrow transplant
- Sepsis
- Congenital hypotonias associated with feeding difficulty or malabsorption
- Renal disease requiring dialysis in the first year of life
- Craniofacial anomalies
- An immune deficiency
- Neonatal abstinence syndrome
- Any other serious condition or acquired condition for which the use of donor human milk derived products is **medical necessary** and supports the treatment and recovery of the child
- Any infant still inpatient within 72 hours of birth without sufficient breast milk available

Donor human milk means human milk that has been contributed to a milk bank by one or more donors.

Milk bank means an organization that engages in the procurement, processing, storage, distribution, or use of human milk contributed by donors.

Mental Health Parity

In no event will the cost share for mental health services be any more restrictive than that for any other **physician** services covered under the plan.

Neurodevelopmental therapy

Eligible health services include rehabilitative and habilitative speech, physical or occupational therapy, but only if it is expected to:

- Restore or improve speech or a body function
- Develop speech or a body function that was lost or delayed because of an **illness** or because of a condition you had when you were born
- Maintain speech or a body function that would get worse because of an **illness** or because of a condition you had when you were born

Nutritional supplements

Eligible health services include amino acid modified preparations, dietary specialized formulas and low protein modified food products for the treatment of inherited metabolic diseases including phenylketonuria and eosinophilic gastrointestinal disorder.

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and intended to be used under the direction of a **health professional** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Exclusions

Your plan does not cover the following under this section:
Any food item, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered above

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Mammograms

Eligible health services include the following routine cancer screenings:

- Mammograms, including 3-D mammograms (tomosynthesis)

The following has been added to or replaced in the *How your plan works* section of your booklet-certificate.

Surprise bill

There may be times when you unknowingly receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill. Review *Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State* that is attached to this certificate.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms

Here are some key terms we use in this section. These terms will help you understand this *COB* section.

Allowable expense means:

- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic surgery** generally is not an allowable expense under this plan.

In this section when we talk about a "plan" through which you may have other coverage for health care expenses, we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here's how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable expenses

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. A plan that does not contain a COB provision is always the primary plan.

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or dependent	The plan covering you as a non-dependent	The plan covering you as a dependent
Exception to the rule above when you are eligible for Medicare	If you or your spouse has Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: • **Online:** Log on to your **Aetna** secure member website at www.aetna.com • **By phone:** Call the number on your ID card	
COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the **calendar year**. *Same birthdays-the plan that has covered a parent longer is primary.	The plan of the parent born later in the year (month and day only).* *Same birthdays-the plan that has covered a parent longer is primary.
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no	The plan of the other parent. But if that parent has no coverage, then their spouse's plan is primary.

	coverage then their spouse's plan is primary.	
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination. See *Child of* content above.	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.
Benefit reserve	The benefit reserve:

Each family member has a separate benefit reserve for each **calendar year**	• Is made up of the amount that the secondary plan saved due to COB • Is used to cover any unpaid allowable expenses • Balance is erased at the end of each year

How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under Medicare.

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age
- Disability
- End stage renal disease

When you are enrolled for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan
A disability other than ESRD and the policyholder has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

Charges that satisfy your Part B deductible will be applied in the order received. We will apply the largest charge first when two or more charges are received at the same time.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

- **Online:** Log on to your **Aetna** secure member website
- **By phone:** Call the number on your ID card

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid, or
- Any other plan that is responsible under these COB rules.

Important note: If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your **provider** should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

All health plans have timely claim filing requirements. If you or your **provider** fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan, you should promptly report to your **providers** and plans any changes in your coverage.

Adding new dependents

If your plan includes coverage for dependents, you can add the following new dependents any time during the year:

- A newborn child - Your newborn child is covered on your plan for the first 31 days after birth
  - When additional **premiums** are required, you must enroll the child within 60 days of birth to keep the newborn covered
  - If you miss this deadline, your newborn will not have benefits after the first 31 days
- An adopted child - You may put an adopted child on your plan on the date the child is placed for adoption
  - "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child
  - When additional **premiums** are required, you must enroll the child within 60 days of placement
  - Your adopted child's coverage will start from the date of placement
  - If you miss this deadline, your adopted child will not have benefits
- A stepchild - You may put a child of your spouse or domestic partner on your plan
  - You must enroll the child within 60 days of the date of your marriage or domestic partnership with your stepchild's parent

- The benefits for your stepchild will begin the first day of the month following the date we receive your completed enrollment information

Domestic Partners

If your plan includes coverage for dependents, you can also enroll the following family members on your plan.

- Your domestic partner and their dependent children

How can you extend coverage during a strike, lockout or other labor dispute?

You have a right to extend coverage for you and your dependents even if you are absent from work because of a strike, lockout or other labor dispute if:

- You were covered on the date you stopped working, and
- You paid your **premium** when due

You can continue your coverage for up to 6 months if you pay your **premiums** to your employer. Your employer will send your payment to **Aetna**. Call the number on your ID card to get the process started. Your coverage will continue until:

- You go to work full-time for another employer
- You do not make the required **premium** payments
- The labor dispute ends, or
- The 6 months continuation period ends

Your **premium** payment will be the same rate you were paying on the date you stopped working. But, if the **premium** amount your employer has to pay changes during the time you are extending your coverage, your **premiums** will also change.

When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible health services**.

When a claim comes in, we decide and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

For claims involving **out-of-network providers:**

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from us • The claim form will provide instructions on how to complete and where to send the form(s)	• You must send us notice and proof as soon as reasonably possible • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges – Any medical documentation you received from your provider
Proof of loss (claim)	• A completed claim form and any additional information required by us	• You must send us notice and proof as soon as reasonably possible

Benefit payment	• Written proof must be provided for all benefits • If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss	• Benefits will be paid as soon as the necessary proof to support the claim is received

Types of claims and communicating our claim decisions

You or your **provider** is required to send us a claim in writing. If you or your dependent goes to a **network provider**, the **network provider** will file the claims. When you go to an **out-of-network provider**, you will have to file the claims. You can request a claim form from us. We will review that claim for payment to the **provider** or to you as appropriate.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim

An urgent claim is one for which the **health professional** treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them.

Post-service claim

A post service claim is a claim that involves health care services you have already received.

Concurrent care claim extension

A concurrent care claim extension occurs when you ask us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization.

During this continuation period, you are still responsible for your share of the costs, such as **copayments/coinsurance** and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

We may need to tell your **health professional** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital.**

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	Within 48 hours or Within 1 business day for an emergency request	5 calendar days	30 calendar days	No later than 24 hours for urgent request* or 5 calendar days for non-urgent request
Request for Extension	Not applicable	Within 5 calendar days	15 calendar days	Not applicable
Additional information request (us)	24 hours	5 calendar days	30 calendar days	Not applicable
Response to receipt of additional information request (you)	48 hours	30 calendar days	45 calendar days	Not applicable

*We have to receive the request at least 24 hours before the previously approved health care services end.

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** if you go to a **network provider** and the **recognized charge** if you go to an **out-of-network provider**, except for your share of the costs.

But sometimes we may pay only some of the claim. And sometimes we may deny payment or service entirely.

We may sometimes:

- Deny
- Change
- Reduce, or
- Terminate your
- Health care services or benefits
- Authorization relating to such services or benefits, or
- Coverage or payment for the health care services or benefits

Such actions are called “adverse benefit determinations.” Other actions that are also called “adverse benefit determinations” include:

- We do not authorize a **stay** in a **hospital** or other facility
- We decide that you or your dependents were not eligible for the coverage when you received the services
- We decide that you have reached your benefit maximums
- Your health care services are excluded, not covered or limited in some way
- We rescind your coverage entirely

Reasons for adverse benefit determinations may be:

- The results of utilization review activities
- The health care services are **experimental or investigational**
- The health care services are not **medically necessary**

If we make an adverse benefit determination, we will tell you in writing.

The difference between a grievance and an appeal

A grievance

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call the number on your ID card, or write us. Your grievance should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the grievance**.** We will let you know if we need more information to make a decision.

An appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us by calling the number on your ID card.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by calling the number on your ID card. You need to include:

- Your name
- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by calling the number on your ID card. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

Urgent care or pre-service claim appeals

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding appeals

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to

tell you about our decision.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	24 hours, but no longer than 72 hours	14 days, or 20 days for an **experimental or investigational** treatment. We will let you know within 72 hours that we have received your appeal		As appropriate to type of claim
Extension to respond (us)	None	16 additional days, if we notify you and provide a reason. We will get your written permission if we need more time beyond the 16 additional days.		

Exhaustion of appeals process

In most situations you must complete the one level of appeal with us before you can pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete our appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally. See the *How to contact us for help* section for details on how to reach us.
- We did not follow all of the claim determination and appeal requirements of Washington or of the Federal Department of Health and Human Services. You will not be able to proceed directly to external review if the violation was:
  - Minor and not likely to influence a decision or harm you
  - For a good cause or beyond our control
  - Part of an ongoing, good faith exchange between you and us

At any time you may contact the Washington Office of the Insurance Commissioner to request an investigation of a grievance or appeal.

External review

External review is a review done by people in an organization outside of **Aetna**. This is called an external review organization (ERO). Sometimes, this is called an independent review organization (IRO).

You have a right to external review if:

- Our claim decision involved medical judgment
- We decided the service or supply is not **medically necessary** or not appropriate
- We decided the service or supply is **experimental or investigational**
- You have received an adverse determination

The notice of adverse benefit determination or final adverse benefit determination we send you will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To **Aetna**
- Within 180 calendar days of the date you received the decision from us

- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

Aetna will contact the ERO that will conduct the review of your claim.

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Will accept additional written information from you for up to five business days after the ERO accepts its assignment
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 30 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the ERO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?

We will tell you of the ERO decision not more than 30 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your **provider** must call us or send us a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse determinations

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment)

For final adverse determinations

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

Recordkeeping
We will keep the records of all grievances and appeals for at least 10 years.

Fees and expenses
We do not pay any fees or expenses incurred by you when you submit a grievance or appeal.

Out-of-network benefits disclosure
Your health plan's out-of-network benefits
Not all health coverage plans provide out-of-network benefits. Please refer to your schedule of benefits for a description of your health plan's out-of-network benefits.

Notice of consumer rights
Washington State has developed a notice of consumer rights. You can find this in your certificate of coverage.

Out-of-network costs
You may choose a doctor in our network. You may choose to visit an out-of-network doctor. We cover the cost of care based on whether the provider, a doctor or hospital, is "in network" or "out of network." We want to help you understand how much we will pay for your
out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care.

"In network" means we have a contract with that doctor. Doctors agree to how much they will charge you for covered services. That amount is often less than what they would charge you if they were not in our network. Most of the time, it costs you less to use doctors in our network. Doctors also agree to not bill you for any amount over their contract rate. All you have to pay is your coinsurance, copayments, and deductible that applies. Your network doctor will handle any precertification your plan requires.

"Out of network" means we do not have a contract for discounted rates with that doctor. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna® health plan may pay some of that doctor's bill. Most of the time, you will pay more money out of your own pocket if you choose to use an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that the plan doesn't recognize. You'll also pay higher copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits. This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure

How to use the transparency tool
Aetna provides online tools to help you determine the cost of health care services and your potential share of those expenses. After logging in to our member website, you can search for procedures and providers to see estimated costs.

Search our network for doctors, hospitals and other health care providers
Use our online provider search tool for the most up-to-date list of health care professionals and facilities. You can get a list of available doctors by ZIP code or enter a specific doctor's name in the search field.

Visit **Aetna.com** and log in. From your secure member website home page, select "Find Care" from the menu bar and start your search.
Our online search tool is more than just a list of doctors' names and addresses. It also includes information

about:

- Where the doctor went to medical school
- Board certification status
- Language spoken
- Hospital affiliations
- Gender
- Driving directions

Obtain an estimated range of the out-of-pocket costs for an out-of-network benefit

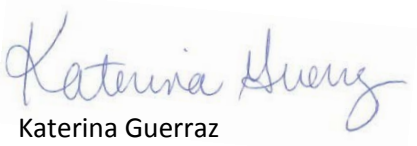
Contact member services at the number on your ID card for help estimating your out-of-pocket cost for an out-of-network benefit. Out-of-network providers do not have a contracted rate with Aetna. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. However, your out-of-pocket costs may be much higher compared to the costs of using a network provider. Your out-of-pocket costs for an out-of-network benefit, if included in your plan, consists of your out-of-network deductible plus your plan coinsurance. To estimate your coinsurance amount, subtract the remaining plan deductible from the provider's billed charge. Then multiply the balance by your coinsurance percentage.

Policies and plans are insured and/or administered by Aetna Life Insurance Company or its affiliates (Aetna).

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Refer to **Aetna.com** for more information about Aetna® plans.

Estimated costs are not available in all markets. The tool gives you an estimate of what you would owe for a particular service based on your plan at that point in time. Actual costs may differ from the estimate if, for example, claims for other services are processed after you get your estimate but before the claim for this service is submitted, or if the doctor or facility performs a different service at the time of your visit

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

Amendment: Washington Medical ET
Issue Date: February 20, 2025