

BENEFIT PLAN

Prepared Exclusively For
El Camino Hospital

Open Choice PPO HDHP

Extraterritorial Riders

Aetna Life Insurance Company

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



Table of Contents

	Page
ET Riders	Included in this document
Alabama Medical	1
Arizona Medical	3
Colorado Medical	6
Florida Medical	10
Georgia Medical	13
Idaho Medical	15
Illinois Medical	17
Indiana Medical	22
Maryland Medical	24
Mississippi Medical	26
Montana Medical	32
Ohio Medical	33
Oregon Medical	36
Tennessee Medical	38
Texas Medical	40
Utah Medical	88
Wisconsin Medical	92

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 Alabama. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

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 therapy associated with the diagnosis of autism spectrum disorder

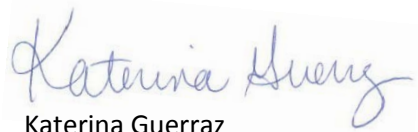
Diabetic supplies, drugs, and insulin important note:

Your cost share will not exceed \$100 per 30 day supply of a covered **prescription** insulin drug.

Pharmacy

All **prescriptions** and refills over a 30 day supply may be filled at a **retail pharmacy** or a **mail order pharmacy**.

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: Alabama 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 Arizona. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Notice

YOUR CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THE CERTIFICATE CAREFULLY.

When you are injured

If someone else caused you to need care – say, a careless driver who injured you in a crash – you may have a right to get money. We are not entitled to that money.

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

The appeal process information packet explains all of your appeal rights. We sent you a copy of this. If you need another copy you can obtain one by calling us. 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.

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. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. We will assign your appeal to someone who was not involved in making the original decision.

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.

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 Arizona Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Arizona Department of Insurance
- 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 Arizona or federal Department of Health and Human Services.

External review

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

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

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

IRO decisions

The IRO will make a decision and notify the Insurance Director. The Insurance Director will notify us, you and your **provider**.

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

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

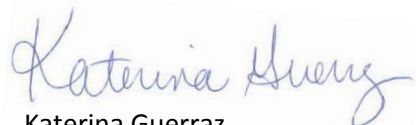
Recordkeeping

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.

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: Arizona 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 Colorado. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Cleft Palate and Cleft Lip Conditions

Eligible health services include services and supplies for the treatment of cleft palate and cleft lip conditions.

Services and supplies include:

- Oral and facial surgery, audiological and otolaryngology assessment and treatment
- Prosthetic treatment to include obturators, speech appliances, and feeding appliances
- Habilitative speech therapy
- Orthodontia at any age

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 for a disabling, progressive or other life-threatening disease or condition, as defined and amended under the September 19, 2000 Medicare national coverage decision regarding clinical trials and all of the following conditions are met:

- Your **physician** recommends participation in the clinical trial because it has the potential to provide a therapeutic health benefit to you
- Your care is provided by a certified, registered, or licensed **provider** working within the scope of their practice
- Your treatment is provided in a facility and by personnel who have the proper experience and training
- Prior to participation in a clinical trial or study, you sign a statement of consent indicating that you have been informed of the procedure, alternative methods of treatment, and the risks associated with participation in the clinical trial or study

Coverage is limited to benefits for routine patient services provided within the network if your plan does not provide coverage for out of network expenses.

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 a disabling, progressive or other life-threatening disease or condition, as defined and amended under the September 19, 2000 Medicare national coverage decision regarding clinical trials.

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

Early intervention services

These are services delivered by a qualified early intervention service **provider** as described under Part C of the Individuals with Disabilities Education Act. They are available for children from birth to age 3 who are eligible for these services. No deductible or copay applies unless this benefit is provided under a qualified High Deductible Plan.

Covered services include:

- Speech and language therapy
- Occupational therapy
- Physical therapy
- Assistive technology

Maternity and related newborn care

Covered services include pregnancy (prenatal), **complications of pregnancy** care, care after delivery and obstetrical services including maternity support services 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 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

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, low protein modified food products and medical foods ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino, organic and fatty acids as well as severe protein allergic conditions.

Except as covered above, the following are not **covered services**:

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

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.

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

Covered services also include additional prosthetic devices for physical and recreational activity that your **physician** orders and determines necessary.

If you receive a prosthetic device as part of another **covered service**, 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

Vision care

If your plan provides coverage for a routine vision exam, you don’t have to access vision care through your **PCP**. You may go directly to a network ophthalmologist or optometrist for **covered services**.

Complications of pregnancy

Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy or caused by the pregnancy, including, but not limited to:

- Acute nephritis
- Nephrosis
- Cardiac decompensation
- Missed abortion
- Non-elective cesarean section
- Termination of ectopic pregnancy
- Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible

Complications of pregnancy do not include conditions associated with the management of a difficult pregnancy such as:

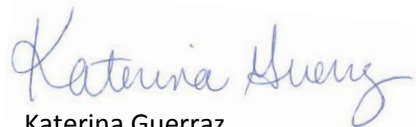
- False labor
- Occasional spotting
- Morning sickness
- **Physician** prescribed rest during pregnancy
- Hyperemesis gravidarum
- Pre-eclampsia

Telemedicine

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service that can be provided electronically by:

- Two-way audiovisual teleconferencing
- Any other method required by 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: Colorado 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**

In no event will the covered amount for Out-Of-Network charges be less than 50% of the covered amount for In-Network charges.

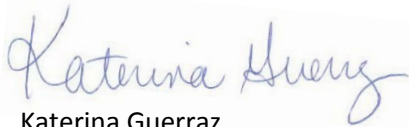
In no event will the covered amount for any covered service or treatment that is not available from an In-Network provider be less than 10% of the covered amount for In-Network charges.

In no event will any Out-Of-Network Deductible be more than four times any In-Network Deductible. If there is no Individual In-Network Deductible, any Out-Of-Network Individual Deductible cannot exceed \$500 per individual.

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

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: 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**:

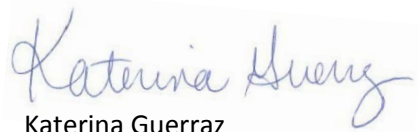
- The related dental service unless specifically listed as a **covered service** in this certificate

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 Idaho. 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 *Eligibility* section of your booklet-certificate.

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
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 60 days after the event date.

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

Abortion

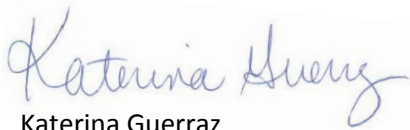
Services and supplies provided for an elective abortion except when the pregnancy places the woman's life in serious danger

Coordination of benefits

Your Coordination of benefits provision has been revised to clarify that “Plan” does not include:

- Hospital indemnity or fixed indemnity coverage
- Accident only coverage
- Specified disease or specified accident coverage
- Limited benefit health coverage
- 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

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: Idaho 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 Illinois. 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 *Introduction* section of your booklet-certificate.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN **OUT-OF-NETWORK PROVIDERS** ARE USED. When you choose to use the services of an **out-of-network provider** for an **eligible health service** in non-emergency situations, benefit payments to **out-of-network provider** are not based upon the amount billed. Your benefit payment will be based on the **recognized charge**.

YOU CAN EXPECT TO PAY MORE THAN THE **COINSURANCE** AMOUNT SHOWN IN THE SCHEDULE OF BENEFITS AFTER THE PLAN HAS PAID ITS PORTION. After the plan has paid its portion of the bill as provided in 215 ILCS 5/356z.3a, **out-of-network provider** may bill you for any amount up to the billed charge.

Other than **coinsurance** and **deductible**, **network providers** agree to accept discount payments for services without additional billing to you. You may obtain information about the participating status of professional providers and out-of-pocket expenses by calling the toll-free number on your ID card.

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

Abortion

Covered services include services and supplies provided by a **physician** for an abortion

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

Immunizations

Covered services include preventive immunizations for infectious diseases.

Doses, recommended ages and recommended population vary.

- Adults:
 - Herpes Zoster
 - Mumps
 - Rubella
- Adults and children from birth to age 18
 - Diphtheria
 - Hepatitis A
 - Hepatitis B
 - Human papillomavirus (HPV)
 - Influenza (flu shot)
 - Measles
 - Meningococcal
 - Pertussis (whooping cough)
 - Pneumococcal
 - Tetanus
 - Varicella (chickenpox)
 - Shingles if you are 60 **years** of age or over
- Children from birth to age 18:
 - Haemophilus influenza type b
 - Inactive poliovirus
 - Rotavirus

The following are not preventive **covered services**:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Low dose mammography screening, for women age 35 and older, (including x-ray examination, digital mammography and breast tomosynthesis) for the presence of occult breast cancer as follows:
 - For women 35-39, a baseline mammogram
 - For women 40 years of age and older, annually
 - For women under 40, with a family or prior personal history of breast cancer, positive genetic testing, or other risk factors, at necessary age and intervals
 - Comprehensive ultrasound screening and MRI of the entire breast(s) when a mammogram demonstrates heterogenous or dense breast tissue, as determined by your **physician**
 - Screening MRI, as determined by your **physician**
- Annual digital rectal exams and prostate specific antigen (PSA) tests as recommended by your, **Physician, PCP**. This includes:
 - Asymptomatic men age 50 and older
 - African-American men age 40 and over
 - Men age 40 and over with family history of prostate cancer
 - Colorectal cancer screening for adults over 50
- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp and a follow-up exam based on an initial screening
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)

- Lung cancer screenings: adults age 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
- Sigmoidoscopies
- Pancreatic cancer screening when medically necessary

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**, OB, GYN or OB/GYN for services including annual Pap smears including surveillance tests for ovarian cancer for women at risk for ovarian cancer.
- Preventive care breast cancer (BRCA) gene blood testing
- Clinical breast exams as follows:
 - For women over 20 **years** of age but less than 40, at least every 3 **years**
 - For women 40 **years** of age and older, annually
- Breast cancer chemoprevention counseling
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- HIV screening and counseling for sexually active women
- Osteoporosis screening for women over age 60 depending on risk factors
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

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 or implant removal
 - Prostheses
 - A physician office visit or in-home nurse visit within 48 hours after discharge

Covered services also include **medically necessary** breast reduction **surgery**.

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.

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

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

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:

For certain drugs, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**

Step therapy is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

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

Important note:

Precertification and **step therapy** requirements do not apply to FDA-approved **prescription** drugs used for the treatment of **substance related disorders**, other than those established by applicable criteria.

Requesting a medical exception

Sometimes you or your **provider** may ask for a medical exception to request coverage for a **prescription** drug that is:

- Not covered
- Discontinued (for reasons other than safety or drug manufacturer withdrawal)
- Ineffective in the treatment of your disease or medical condition
- Likely to be ineffective or adversely affect the drug's effectiveness or patient compliance based on:
 - Your known relevant physical and mental characteristics
 - The known characteristics of the drug regimen from a step therapy requirement or dosage limitation

You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. We will process your request through our standard medical exception process within 72 hours of receipt. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members. If the medical exception request is approved by us, you will receive coverage for the **prescription** drug according to the terms of your group policy.

You, someone who represents you or your **provider** may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **provider** of our decision. In the case of denial, we will provide you with:

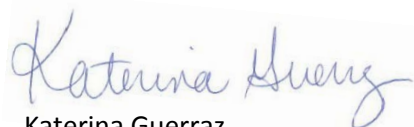
- The reason for the denial
- An alternate covered medication (if applicable)
- Information for submitting an appeal of the denial.

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

Benefit payments and claims

If benefits are not paid within 30 days after proof of loss is received, the **network provider** is entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than \$1 may not be paid.

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: Illinois 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/doi>

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

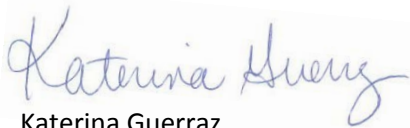
- Foster children
- A child subject to legal guardianship
- Children you are responsible for under a qualified medical support order or court order
- Grandchildren in your legal custody

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
Executive Vice President, Chief Operating Officer
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

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 Maryland. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Habilitation therapy services

Habilitation therapy services are services and devices, including occupational therapy, physical therapy and speech therapy, that help you keep, learn or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age). You are covered up to at least age 20. The services must follow a specific treatment plan, ordered by your **physician**. The services must be performed by a:

- Licensed or certified physical, occupational or speech therapist
- **Hospital, skilled nursing facility** or hospice facility
- **Home health care agency**
- **Physician**

Outpatient physical, occupational, and speech therapy

Covered services include:

- Physical therapy
- Occupational therapy
- Speech therapy (speech function is the ability to express thoughts, speak words and form sentences)

The following are not **covered services**:

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

Applied behavior analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions that:

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

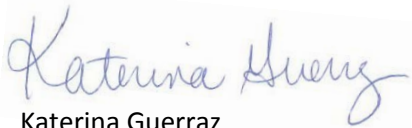
Autism spectrum disorder

Autism spectrum disorder is defined in the most recent edition of the International Classification of Diseases, Tenth Edition (ICD-10).

Covered services include services and supplies provided for:

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

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: Maryland 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 Mississippi. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Retail Pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of **prescription** drugs.

Timely payment of claims

1. All benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the insurer receives a clean claim containing necessary medical information and other information essential for the insurer to administer preexisting condition, coordination of benefits and subrogation provisions. A “clean claim” means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

A clean claim does not include any other the following:

- a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
- b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
- c. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or

- d. Claims submitted by a provider more than thirty (30) days after the date of services; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

Not later than twenty-five (25) days after the date the insurer actually receives an electronic claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation an information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the insurer actually receives a paper claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation an information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the insurer shall be paid within twenty (20) days after receipt.

For the purposes of this provision, the term "pay" means that the insurer shall either send cash or a cash equivalent by the United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) in a properly addressed, postpaid envelope, or if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or the insured.

2. Subject to due written proof of loss, all accrued benefits for loss for which this policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days after receipt of due written proof.
3. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or to the insured (where the claim is owed to the insured) interest on accrued benefits at the rate of three percent (3%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar (\$1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

In the event the insurer fails to pay benefit when due, the person entitled to such benefits may bring action to recover such benefits, any interests which may accrue as provided in subparagraph 3 of this paragraph (h) and any other damages as may be allowable by law. If it is determined in such action that the insurer acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the person entitled to such benefits (health care provider or insured) shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

Payment of claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed in this policy and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured. When payments of benefits are made to an insured directly for medical care or services rendered by a health care provider, the health care provider shall be notified of such payment. If the insured provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the insurer shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the **provider**, who may not bill or collect from the insured any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the insured that are noncovered benefits.

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.

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 within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

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 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

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.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

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.

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.

External review

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO).

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

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

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also 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 the U.S. Office of Personnel Management
- 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 ERO. We will pay for information we send to the ERO plus the cost of the review.

The ERO 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 ERO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?

We will give you the ERO 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 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 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 (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 (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.

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

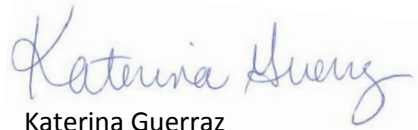
Recordkeeping

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.

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: Mississippi 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.

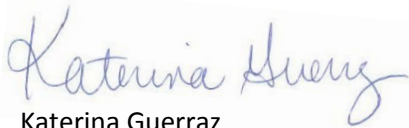
Important note: The following apply only if you live in Montana. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

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

Treatment of inborn errors of Metabolism

For purposes of this benefit, “medical foods” means nutritional substances in any form that are specifically formulated to be distinct in one or more nutrients present in natural foods and are intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foods or certain nutrients contained in ordinary foods and to be used under the direction of a **physician** for the dietary treatment essential to optimize growth, health and metabolic homeostasis.

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: Montana 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 Ohio. 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.

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. This would include coverage of **injury** or sickness and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. 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. The decision can be made by a certified nurse-midwife in collaboration with the attending **physician**.

Precertification is only required for maternity and newborn **stays** that exceed the standard length of **stay**.

If the mother is discharged earlier, **covered services** include post-delivery home visits for follow-up care for the mother and newborn when recommended, ordered and supervised by a health care **provider**, which includes a **physician** or advanced practice registered nurse. If the mother is discharged earlier than the minimum lengths of **stay**, **covered services** include all follow-up care received within 72 hours after discharge. If the mother receives at least the minimum number of hours of inpatient care, we will pay for **covered services** as recommended by the attending **physician**. The home visits include:

- Parent education
- Assistance training in breast or bottle feeding
- Physical assessment of the newborn and mother
- The collection of an adequate sample for the hereditary and metabolic newborn screening
- Clinical tests and other services that are in line with follow-up care recommended in the protocols and guidelines developed by national organizations representing the **providers**

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
- Surrogacy when the surrogate is not a covered person

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

Your newborn child is covered on your health plan for the first 31 days from the moment of birth at no cost.

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

Continuation of coverage - State of Ohio

Your rights

Ohio law gives some people the right to keep their health coverage for 12 months after active employment ends. To be eligible for this coverage:

- You must have been employed for three consecutive months immediately before coverage ended
- You could not have voluntarily ended your employment
- Your employment could not have ended for gross misconduct
- You cannot be covered or eligible for any other group plan, Medicare, or COBRA

When I will receive continuation information

The chart below lists who is responsible for providing notice, the type of notice, and the timing.

Employer/Group health plan notification requirements

Notice	Requirement	Deadline/method
General notice - Aetna	Notice to you and your dependents of continuation rights	By this certificate
Notice of qualifying event – employer	Your active employment ends for reasons other than gross misconduct	When your employer notifies you that your employment has ended

How to enroll

You enroll by sending an application and paying the premium to your employer. The application will tell you how to enroll and how much it will cost.

When your first premium payment is due

Your first premium payment must be made:

- Within 31 days after your coverage ends
- Within 10 days if your employer notified you that your employment has ended before your coverage termination date
- Within 10 days if your employer notified you of your right to continue coverage after your coverage would have terminated

How much coverage will cost

You and your dependents will pay a monthly premium of 100% of the total plan costs.

When coverage ends

Coverage ends if:

- Coverage has continued for the maximum period
- The plan ends. If the plan is replaced, you may continue under the new plan
- You and your dependents fail to make the necessary premium payments on time
- You or a covered dependent become entitled to benefits under Medicare
- You or a covered dependent become covered under another plan

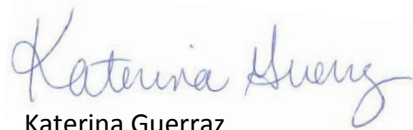
The following has been added to or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate.

How you can extend coverage for your child beyond the plan age limits

You have the right to extend coverage for your child beyond the plan age limits if your child meets all the following requirements:

- Your child is an Ohio resident or, if not a resident of Ohio, the child is a full-time student at an accredited public or private institution of higher education
- Your child is eligible for coverage through their employer who offers any health plan
- Your child meets all other eligibility requirements
- Your child or you requests continuation of coverage within 31 days of your child's attainment of the plan age limit, or during an open enrollment
- Your child or you agree to pay the full cost of the child's coverage

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: Ohio 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 *How your plan works* section of your booklet-certificate.

Precertification

In accordance with state law timeframes, we will tell you and your **physician** in writing of the **precertification** decision or if we need additional information. An approval is valid for 180 days as long as you remain enrolled in the plan.

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.

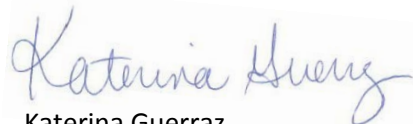
The following has been added to or replaced in the *Eligibility, Starting and Stopping Coverage* section of your booklet-certificate.

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 Tennessee. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

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**:

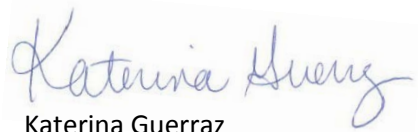
- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising **experimental or investigational** interventions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

Participation in a clinical trial will not be the sole reason to deny coverage.

Recovery of overpayments

We sometimes pay too much for **covered services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid, you or your **provider**, to return what we paid. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake up to 18 months after the overpayment was received, except in cases of fraud.

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: Tennessee 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

Preferred Provider Disclosure Notice

- You have the right to an adequate network of preferred **providers** (also known as "network providers").
 - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
 - If you relied on materially inaccurate **directory** information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network **deductible** and out-of-pocket maximum.
- You have the right, in most cases, to obtain estimates in advance:
 - from **out-of-network providers** of what they will charge for their services; and
 - from your insurer of what it will pay for the services.
- 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 the **directory** is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.
- If you are treated by a **provider** or **hospital** that is not a preferred **provider**, you may be billed for anything not paid by the insurer.
- If the amount you owe to an out-of-network **hospital**-based radiologist, anesthesiologist, pathologist, emergency department **physician**, neonatologist, assistant surgeon, out-of-network emergency care **provider** or any out-of-network **provider** working at a network facility is greater than \$500 (not including your **copayment**, **coinsurance**, and **deductible** responsibilities) for services received in a network **hospital**, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.

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 trial that is exempt from having such an investigational new drug application

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:

Once you have met your **deductible**, 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 audilogically 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**.

Partial fill dispensing for certain prescription drugs

We allow a partial fill of your **prescription** if:

- Your **pharmacy** or **prescriber** tells us that:
 - The quantity requested is to synchronize the dates that the **pharmacy** fills your **prescription drugs**
 - The synchronization of the dates is in your best interest
- You agree to the synchronization

Your out-of-pocket expenses will be prorated based on the number of days' supply.

Prescription eye drops

You may refill **prescription** eye drops to treat a chronic eye disease or condition if:

- The original **prescription** states that additional quantities are needed
- The refill does not exceed the total quantity of dosage units stated on the original **prescription**, including refills
- The refill dispensed on or before the last day of the prescribed dosage period and not earlier than the:
 - 21st day after the date a 30-day supply is dispensed
 - 42nd day after the date a 60-day supply is dispensed
 - 63rd day after the date a 90-day supply is dispensed

Anti-cancer drugs taken by mouth

Covered services include any drug prescribed for cancer treatment, including chemotherapy drugs. 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.

Coverage for oral anti-cancer **prescription** drugs will not be less favorable than for intravenously or injected anti-cancer medications 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. For more information see the *How your plan works – Medical necessity and preauthorization requirements* section.

Nutritional supplements

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.

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 are covered to the same extent that the plan covers drugs that are available only on the orders of a **physician**.

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	Out-of-network
Preventive care services	100% per visit, no deductible applies	60% per visit after deductible No deductible , copayment or coinsurance applies to immunizations for children through age 6
Breast feeding counseling and support	100% per visit, no deductible applies	60% per visit after deductible
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	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 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months 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: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no deductible applies	60% per visit after deductible
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no deductible applies	60% per visit after deductible
Counseling for obesity, healthy diet	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.	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	60% per visit after deductible
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no deductible applies	60% per visit after deductible
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (contraception counseling)	100% per visit, no deductible applies	60% per visit after deductible
Family planning services (contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting

Immunizations	100%, no deductible applies	60% after deductible No deductible, copayment or coinsurance applies to immunizations for children through age 6
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	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	60% per visit after deductible
Mammogram limits	Unlimited 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.	Unlimited 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	Unlimited	Unlimited
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 <i>Contact us</i> section	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 <i>Contact us</i> section
Routine lung cancer screening	100% per visit, no deductible applies	60% per visit after deductible
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no deductible applies	60% per visit after deductible
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	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	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	60% per visit after deductible
Pap smear or screening using liquid based cytology methods	One pap smear every 12 months for women age 18 or older	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	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	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	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
Limit	1 visit	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 designated network cost sharing level during the transitional period.	Your claim will be paid at the designated 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 entered your second trimester, 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: ○ Major medical coverages that are superimposed over base plan hospital and surgical benefits ○ 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 as 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 and 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 than 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 determinations* 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 determinations* 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 30 th 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 complaint* 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 use 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
 - A grandchild whose parent is already covered as a dependent on this plan

*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 to continue coverage	Within 60 days of the qualifying 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 lesser 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.

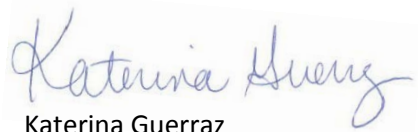
Repayment of these medical expenses for your dependent child will be paid to the Texas Health and Human Services Commission if, when you submit proof of loss, you notify us in writing that:

- 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.

In no event will the covered amount for Out-Of-Network charges be less than 50% of the covered amount for In-Network charges.

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 Utah. 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.

Adoption benefit

Covered services include an adoption benefit up to \$4,000 and apply the same **copays, deductibles, and coinsurance** as any other maternity service.

Coverage is limited to the following requirements:

- The adopted child has been placed with you within 90 days from birth.
- The adopting parent(s) must submit copies of the placement papers to us.

We may seek reimbursement for the adoption benefit if:

- The post placement evaluation disapproves the adoption.
- A court rules the adoption may not be finalized.

Important note:

If both adopting parents have maternity coverage provided by different insurers, we will coordinate payment with the other plan and the total benefit will not exceed \$4,000. If more than one child from the same birth is adopted, only one benefit is applied.

Applied behavior analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis.

Applied behavior analysis is an educational service that is the process of applying interventions that:

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

Important note:

Applied behavior analysis may require **precertification** by us. See the *How your plan works – Medical necessity and precertification* section.

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

Abortion

Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger, or if the fetus has a defect that is documented by a physician or physicians to be uniformly diagnosable and ultimately lethal.

Behavioral health treatment

Services for the following based on categories, conditions, diagnoses, or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:

- Education service, including special education service, remedial education service, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Educational services

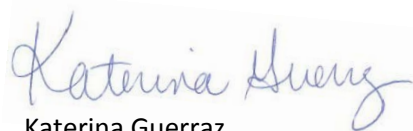
Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
 - Special education
 - Remedial education
 - Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
 - Job training
 - Job hardening programs
- Educational services, schooling or any such related or similar program.

Diabetic supplies, drugs, and insulin important note:

Regardless of the tier prescribed, your cost share will not exceed \$27 per 30-day supply of a covered **prescription** insulin drug. No **deductible** applies for diabetic supplies and insulin.

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: Utah Medical ET
Issue Date: February 20, 2025

Aetna Life Insurance Company



NOTICE OF PROTECTION PROVIDED BY UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This disclaimer provides a **brief summary** of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
 - \$500,000 in death benefits
 - \$200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
 - \$500,000 for health benefit plans
 - \$500,000 in disability income insurance benefits
 - \$500,000 in long-term care insurance benefits
 - \$500,000 in other types of health insurance benefits
- Annuities
 - \$250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at <https://www.ulhiga.org/>, or contact:

Utah Life and Health Insurance Guaranty Assoc.	Utah Insurance Department
450 S. Simmons Way, Suite 650	4315 S. 2700 W., Suite 2300
Kaysville, UT 84037	Taylorsville, UT 84129
(801) 320-9955	(801) 957-9200

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 Wisconsin. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Covered benefits

We pay **covered benefits** described in your Booklet-Certificate based on **negotiated charges** for **network providers** and the **recognized charge** for non-**network providers** which may be less than the actual charge.

Hearing aids

Hearing aid means:

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

Covered services include prescribed hearing aids and the following hearing aid services for covered persons through age 17:

- 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
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- More than 1 hearing aid per ear every 3 years

Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Dependent children

If your plan covers dependent children, they also include children who meet all the following requirements:

- A student, regardless of age
- Called to federal active duty in the national guard or in a reserve component of the U.S armed forces while the child is a student and
- Under 27 years of age when called to federal active duty

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.

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

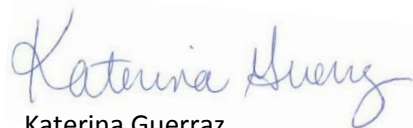
- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

Your newborn child is covered on your health plan for the first 60 days from the moment of birth.

To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 60 day period. We encourage you to enroll your child within 60 days of birth even when coverage does not require payment of an additional premium contribution for the newborn. If you miss this deadline, your newborn will not have health benefits after the first 60 days unless you make all past-due payments plus 5.5% interest per year on those payments within one year after birth.

For all other events, we must receive a completed enrollment form not more than 31 days after the event date.

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: Wisconsin Medical ET

Issue Date: February 20, 2025