Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2022

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.

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

Who can be on your plan (who can be your dependent)

You can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your "dependents".)

- Your spouse
- Your domestic partner who meets the rules set by the **policyholder**.
  - To be eligible for coverage, a domestic partner is a person who certifies the following as of the date of enrollment:
    - He or she is your sole domestic partner and intend to remain so indefinitely
    - He or she is not married to anyone else
    - He or she is not registered as a member of another domestic partnership within the past 6 months
    - He or she is of the age of consent in your state of residence
    - He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside
    - He or she has cohabitated and resided with you in the same residence for the past 6 months and intends to cohabitate and reside with you indefinitely
    - He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses
    - He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage
    - He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
      - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property
      - Common ownership of a motor vehicle
      - Driver's license with a common address
      - Proof of joint bank accounts or credit accounts
      - Proof of designation as the primary beneficiary for life insurance or retirement benefits or primary beneficiary designation under your will
      - Assignment of a durable property power of attorney or health care power of attorney.
- Your dependent children – your own or those of your spouse or domestic partner
  - The children must be under 26 years of age, and they include:
    - Your biological children
    - Your stepchildren
    - Your legally adopted children*,
    - Your foster children, including any children placed with you for adoption and any child when you become a party in a suit to adopt a child.
    - Any children you are responsible for under a qualified medical support order or court-order (without regard to whether or not the child resides with you and whether or not the child resides in the **service area**)
    - Your grandchildren in your court-ordered custody
    - A grandchild who at the time of application, is your dependent for federal tax purposes
    - Any other child with whom you have a parent-child relationship

    *Your adopted child may be enrolled as shown in the [*When you can join the plan*] section at your option, after the date:
    - You become a party in a suit for adoption, or
    - The adoption becomes final

You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive verbal or written enrollment information. 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.
- An adopted child - 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 party in a suit to adopt the child or the adoption is complete.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after you become party in a suit to adopt the child or the adoption is complete.
  - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other health plan of any covered dependent

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
  - You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.
- When a court orders that you cover a current spouse or domestic partner or a minor child on your health plan.
- Your employer offers multiple health benefit plans and you chose a different health plan during open enrollment.
- Your child no longer has coverage under the Child Health Plan for Certain Low-Income Children Program or Title XIX of the Social Security Act (other than coverage solely for benefits under the Program for Distribution of Pediatric Vaccines).

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Item 2 found in the first *Important notes* subsection of the *Eligible health services under your plan, Preventive care and wellness* section of your booklet-certificate is revised to add the following:

Except for diagnostic mammograms, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.

The following content is added to the *Eligible health services under your plan, Preventive care and wellness* section of your booklet-certificate:

Eligible health services also include:

- For covered newborns, an initial **hospital** checkup and the administration of the newborn screening tests as required by applicable Texas law including the cost of a newborn screening test kit in the amount provided by the Department of State Health Services.

Preventive care immunizations

Eligible health services include immunizations provided by your **physician, PCP** or other **health professional** for infectious diseases.

Immunizations for adults age 18 or more	Immunizations for children from birth to age 18
• Hepatitis A • Hepatitis B • Herpes zoster • Human papillomavirus • Influenza • Measles, mumps, rubella • Meningococcal • Pneumococcal • Tetanus, diphtheria, pertussis Varicella	• Diphtheria, tetanus, pertussis • Haemophilus influenzae type b • Hepatitis A • Hepatitis B • Human papillomavirus • Inactivated poliovirus • Influenza • Measles, mumps, rubella • Meningococcal • Pneumococcal • Rotavirus • Varicella • Any other immunization that is required for the child by law

Eligible health services also include immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Preventive care immunizations		
Performed in a facility or at a **physician's** office	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit No **deductible** or **coinsurance** applies for children through age 6
Limited to:		
Routine physical exams for adults age 18 or more	As shown in the booklet-certificate	As shown in the booklet-certificate
Routine physical exams for children from birth to age 18	As shown in the booklet-certificate	As shown in the booklet-certificate
Additional maximum age and visit limits per Calendar Year	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on the back of your ID card.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms (All forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

Unless otherwise stated in the Schedule of benefits, these benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a network **provider** who is an OB, GYN or OB/GYN.

Routine cancer screenings **(applies whether performed at a physician's, PCP, specialist office or facility)**		
Routine cancer screenings	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Mammogram maximums	1 low-dose mammogram every 12 months for covered persons age 35 or older For covered persons of any age, subject to any age, family history and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force The comprehensive guidelines supported by the Health Resources and Services Administration	1 low-dose mammogram every 12 months for covered persons age 35 or older For covered persons of any age, subject to any age, family history and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force The comprehensive guidelines supported by the Health Resources and Services Administration
Prostate specific antigen (PSA) tests maximums	1 PSA test every 12 months for covered persons age 50 and older 1 PSA test every 12 months for covered persons age 40 and older with a family history of prostate cancer, or other risk factor	1 PSA test every 12 months for covered persons age 50 and older 1 PSA test every 12 months for covered persons age 40 and older with a family history of prostate cancer, or other risk factor
Fecal occult blood tests maximums	1 occult test every 12 months for covered persons age 50 or older	1 occult test every 12 months for covered persons age 50 or older
Sigmoidoscopies maximums	1 flexible sigmoidoscopy every 5 years for covered persons age 50 or older	1 flexible sigmoidoscopy every 5 years for covered persons age 50 or older
Colonoscopies maximums	1 colonoscopy every 10 years for covered persons age 50 or older	1 colonoscopy every 10 years for covered persons age 50 or older
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*

Additional maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on the back of your ID card.
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		

Dental care services and anesthesia in a hospital or surgery center

Eligible health services include dental care and anesthesia in a **hospital** or **surgery center** only if your **provider** tells us you:

- Have a physical, mental, or medical condition that requires you be treated in a **hospital** or **surgery center**
- Are developmentally disabled
- Are in poor health and have a medical need for general anesthesia

Home health care

Eligible health services include home health care services 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 your needing to stay in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home.
- The services are a part of a **home health care plan**.
- The services are **skilled nursing services**, home health aide services or medical social services, furnishing of medical equipment and supplies (other than drugs or medicines) or are short-term speech, physical, respiratory 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.

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

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

Emergency services and urgent care

Eligible health services include services and supplies for the treatment of an **emergency medical condition** or an **urgent condition**.

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 you in a **hospital** emergency facility or comparable facility, necessary to determine if an **emergency medical condition** exists
- Treatment to stabilize your condition
- Care in an emergency 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

As always, you can get **emergency services** from **network providers**. However, you can also get **emergency services** from **out-of-network providers**. 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 charge. Please contact Member Services 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

Your coverage for **emergency services** and urgent care from **out-of-network providers** ends when **Aetna** and the attending **physician** determine that you are medically able to travel or to be transported to a **network provider** if you need more care.

As it applies to in-network coverage, you are covered for follow-up care.

Autism spectrum disorder

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

Eligible health 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 only 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
- Occupational therapy
- Physical therapy
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder

Important note:
Applied behavior analysis requires **preauthorization** by **Aetna**. You are responsible for obtaining **preauthorization** if you are using an **out-of-network provider**.

Autism spectrum disorder		
Autism spectrum disorder treatment	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Autism spectrum disorder diagnosis and testing	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Applied behavior analysis	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.

Diabetic equipment, supplies and education

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin and insulin analog preparations
  - Diabetic needles and syringes
  - Injection aids, including devices used to assist with insulin injection and needleless systems
  - Diabetic test agents, including but not limited to, visual reading and urine test strips and tablets
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Non-prescription medications for the purpose of controlling blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
  - 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
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training. We will also cover training for a person who cares for you, if a **provider** sends a written order.

Eligible health 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**

This coverage is for the treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.

Diabetic equipment, supplies and education		
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services. After your child is born, **eligible health services** include:

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 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

If you and your **physician** agree to a shorter **stay**, you and your newborn will receive timely post-delivery care. A **physician**, registered nurse, or other licensed health care **provider** can provide the post-delivery care. You can choose to get the post-delivery care in:

- Your home
- A health care **provider's** office
- A health care facility
- Another location determined to be appropriate under applicable Texas law

We will cover congenital defects for a newborn the same as we would for any other illness or injury.

Coverage also includes the services and supplies needed for circumcision by a **provider**.

Pregnancy complications

Eligible health services include services and supplies from your **provider** for pregnancy complications of a female employee only.

Pregnancy complications means problems caused by pregnancy that pose a significant threat to the health of the mother or baby, including:

- Hyperemesis gravidarum (pernicious vomiting of pregnancy); toxemia with convulsions; severe bleeding before delivery due to premature separation of the placenta from any cause; bleeding after delivery severe enough to need a transfusion or blood
- Acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity.
- Amniotic fluid tests, analyses, or intra-uterine fetal transfusion made for Rh incompatibility
- An emergency medical cesarean section due to pregnancy complications
- Miscarriage if not elective or therapeutic
- Termination of ectopic pregnancy

The plan does not cover a scheduled or non-emergency cesarean delivery under the pregnancy complications benefit.

We will cover pregnancy complications the same as we would for any other **illness** or **injury**.

Mental health treatment

Eligible health services include the treatment of **mental 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**, 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** 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** and **telehealth** consultation).
  - Individual, group and family therapies for the treatment of mental health.
  - 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 the following criteria are met:
      - You are homebound.
      - 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 to avoid placing you at risk for serious complications.
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation
    - Peer counseling support by a peer support specialist
      - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider.**

Coverage for Mental health treatment is provided under the same terms, conditions as any other **illness**.

Reconstructive surgery and supplies

Eligible health 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 and prostheses.
- Unless you or your **physician** decide that a shorter time period for inpatient care is appropriate, **eligible health services** for reconstructive breast **surgery** include:
  - 96 hours of inpatient care following a mastectomy
  - 48 hours of inpatient care in a network **hospital** after a lymph node dissection for treatment of breast cancer.
- 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 purpose of the **surgery** is to improve function or attempt to create a normal appearance.

The following content is added in the *Eligible health services under your plan, Diagnostic lab work and radiological services* subsection of the *Specific therapies and tests* section of your certificate:

Important Note:
Once you have met your **deductible**, your cost share for diagnostic mammograms will be the same as mammograms performed for routine cancer screenings as described in the *Preventive care and wellness* section. Diagnostic mammograms are not subject to any age limitation.

Diagnostic follow-up care related to newborn hearing screening

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

Cardiovascular disease testing

Eligible health services include certain lab tests for the early detection of cardiovascular disease when you have:

- Diabetes, or
- An intermediate or higher risk of getting coronary heart disease based on the 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

Chemotherapy

Eligible health services for chemotherapy depends 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**.

Eligible health services also include oral 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 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. See the *Preauthorization* section for details.

Inpatient and outpatient treatment for acquired brain injury

Eligible health 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
- Psychosocial 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

Eligible health 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.

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

- Within the scope of their license, and

Within the scope of the services provided under and accredited rehabilitation program for brain injury

Inpatient and outpatient treatment for acquired brain injury		
Acquired brain injury	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when you have cancer or **terminal illnesses** and all of the following conditions are 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 that you may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The 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. This requirement does not apply to procedures and treatments that do not require FDA approval.

- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred to you by a **provider** in connection with participation in an "approved clinical trial" as a “qualified individual” for cancer or other life-threatening disease or condition, as those terms are 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 of 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
  - For those approved by the Departments of Veterans Affairs, Defense or Energy, the study or investigation must have been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines:
    - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health
    - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

Hearing aids and cochlear implants and related services

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

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

Nutritional supplements

Eligible health services include formula and low protein modified food products ordered by a **physician** for the treatment or diagnosis 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.

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

Orthotic devices

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

We will cover the same type of devices that are covered by Medicare. Your **provider** will tell us which device best fits your needs. 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 unless you misuse or lose the device. Examples include:
  - 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

Osteoporosis

Eligible health services include the diagnosis, treatment and management of osteoporosis by a **physician**. The services include Food and Drug Administration approved technologies, including bone mass measurement.

Prosthetic devices

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

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

Prosthetic device means:

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

Coverage includes:

- Repairing or replacing the original device unless you misuse or lose the device. Examples include:
  - 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

Diabetic supplies

Eligible health services include but are not limited to the following diabetic supplies upon **prescription** by a **prescriber**:

- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine monitoring and/or visual reading
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs
- Insulin and insulin analogs
- Prescriptive and nonprescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

See your medical plan benefits for coverage of blood glucose meters and insulin pumps.

Off-label use

U.S. Food and Drug Administration (FDA) approved **prescription drugs** and health care services related to the administration of these **prescription drugs** may be covered when the off-label use of the drug has been approved by the FDA for your condition(s). Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your condition by a prescription drug compendium
- Substantially accepted peer-reviewed medical literature
- Use for your condition (s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your condition (s) is equal to the dosage for the same condition (s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above.
  - The dosage has been proven to be safe and effective for your condition (s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Health care services related to off-label use of these drugs may be subject to **preauthorization**, **step therapy** or other requirements or limitations.

Orally administered anti-cancer drugs, including chemotherapy drugs

Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication. 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. See the *Preauthorization* section for details.

The following language is revised within the *What preauthorization requirements apply step therapy* provision within the *Eligible health services under your plan- Specific conditions- Outpatient prescription drugs* section of your booklet-certificate:

Step therapy will not apply to **prescription drugs** used for the treatment of stage-four advanced, metastatic cancer or associated conditions.

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 a member of **Aetna** 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 an out-of-network provider	**If you are a current enrollee and 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 calling the toll-free number on your ID card.	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, 90 days. This date is based on the date the **provider** terminated their participation with us.

	If you have a terminal illness and your provider stops participation with Aetna
Request for approval	Your **provider** should call us for approval to continue any care. You can call Member Services at the number on the back of your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to nine (9) months. This date is based on the date the **provider** terminated their participation with **Aetna**.
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 Member Services at the number on the back of your ID card 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 the 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.

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

The following language is added to the Special financial responsibility provision in the What the plan pays and what you pay section of your booklet-certificate:

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."

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

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

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from the policyholder not later than 20 days after the date of loss. • The claim form will provide instructions on how to complete and where to send the form(s).	• We must send you a claim form within 15 business days of your request. • If the claim form is not sent on or by the 16th day, you are considered to have complied with the requirements for submitting proof of loss. • You may send us: - A description of services - Itemized bill of charges - Any medical documentation you received from your **provider**

Notice	Requirement	Deadline
Proof of loss (claim)	• A completed claim form and any additional information required by us.	• No later than 90 days after you have incurred expenses for **covered benefits**. • We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible. • Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.
Benefit payment	• Written proof must be provided for all benefits. • If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.	• We will accept or reject a claim not later than 15 business days of receiving all items, statements and forms. • Benefits will be paid not later than 5 business days after the date the notice of acceptance is sent. • If we reject the claim the written notice will include the reason for denial. • All benefits payable will be paid no later than 60 calendar days from the date proof of loss is received.

Types of claims and communicating our claim decisions

You or your **provider** are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **provider** or to you as appropriate.

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

Urgent care claim

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

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

Pre-service claim

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

Retrospective claim

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

Concurrent care claim extension

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

Concurrent care claim extension decision

You or your **provider** may ask for a concurrent care claim extension to request more services. We will tell you when we make the decision for such a request. If we make an adverse determination, you will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an independent review organization if the situation is eligible for independent review.

We will not reduce or deny coverage for services that we have already approved. During the concurrent care claim extension period, you are still responsible for your share of the costs, such as **copayments**/**coinsurance** and **deductibles** that apply to the service or supply. If your request for extended services is not approved after your adverse determination appeal, and we support the decision to reduce or terminate such services, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of how much time we have to tell you about our decision on a **preauthorization** request, a concurrent care authorization request and a retrospective review.

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

Initial claim determinations				
Type of notice	**Initial determination (us)**	**Extensions**	**Additional information request (us)**	**Response to additional information request (you)**
Pre-service claim	No later than 3 calendar days after we receive the request	Not applicable	Not applicable	Not applicable
Concurrent care claim If you are hospitalized (may include concurrent care claim of **hospital stays**)	No later than 24 hours after we receive the request, followed by written notification within 3 business days	Not applicable	Not applicable	Not applicable
If you are not hospitalized	No later than 3 calendar days after we receive the request	Not applicable	Not applicable	Not applicable
If you are currently receiving **prescription drugs** or intravenous infusions	No later than the 30th day before the date on which the **prescription drugs** or intravenous infusions will be discontinued	Not applicable	Not applicable	Not applicable
Care to make sure you are stable following emergency treatment (post-stabilization) or for a life-threatening condition	No later than one (1) hour after we receive the request	Not applicable	Not applicable	Not applicable
Requests for **step therapy** exception (non-emergency)	No later than 72 hours after we receive the request	Not applicable	Not applicable	Not applicable

Initial claim determinations				
Type of notice	**Initial determination (us)**	**Extensions**	**Additional information request (us)**	**Response to additional information request (you)**
Requests for **step therapy** exception (emergency)	No later than 24 hours after we receive the request	Not applicable	Not applicable	Not applicable
Acquired brain injury	No later than 3 business days after we receive the request	Not applicable	Not applicable	Not applicable
Retrospective review	30 days	15 days	30 days	45 days

*If we approve the care and services, we will send you a letter no later than 2 business days after we receive the request. The *Adverse determinations* section explains how and when we tell you about an adverse determination.

Adverse determinations

We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized amount** with an **out-of-network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an "adverse determination". It is also an "adverse determination" if we rescind your coverage entirely.

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

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

It is also an **adverse determination** if our determination is based on:

- Your eligibility for coverage
- Your plan's exceptions *What your plan doesn't cover – some eligible health service exceptions*

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

- The main reason for the denial
- The clinical basis for the 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 booklet-certificate
  - Requests for step therapy exception

The chart below tells you 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 intravenous infusions that you are currently receiving**	**Retrospective review**
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 three 3 business days to you and your **provider**	Within 3 business days to you and your **provider**	No later than the 30th day before the date 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 you no later than the times shown in the chart above.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call the toll-free number on your ID card, or write Member Services. Some other examples of complaints are when you are not happy with:

- How we have administered the plan
- How we have handled the appeal process
- When we deny a service that is not related to **medical necessity** issues
- The manner in which a service is provided
- A disenrollment decision

But 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.

We will review the information and provide you with 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.

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.

An 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 processes for both types of appeals.

Appeal of a complaint

You can ask us to re-review your complaint. You can appeal to us verbally or in writing.

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. 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.
- **Aetna** representatives who were not involved in making the initial decision.
- **Providers** (including **specialists**) who were not involved in the initial 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 **physicians** or **providers** consulted during the review
- The name and affiliation of all **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.

Appeals of adverse determinations

You can appeal our adverse determination. We will assign your appeal to someone who was not involved in making the original decision.

You can appeal by sending a written appeal to the address on the notice of adverse determination, or by calling the toll-free number on your ID card. 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
- If you appealed verbally or by phone, we will send you a one page appeal form to be filled out by you or your authorized representative.

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

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 determination.

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.

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

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 determinations

The amount of time that we have to tell you about our decision on an appeal of an adverse determination 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 verbally or in writing. If we tell you verbally, we will also send you a letter within 3 calendar days after the verbal notice.

Type of claim	**Our response time**
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 (based on the medical urgency of the case) but no later than 1 business day or 72 hours (whichever is less) from 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

Type of claim	Our response time
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 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 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 days 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 show good cause for specialty review. The request must be made not 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 appeals process

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

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

You do not have to complete the internal appeal process when:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the independent review process.

- We did not follow all of the claim determination and appeal requirements of 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 internal review process.
- 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 **Aetna**. This is called an independent review organization (IRO).

You have a right to independent review only if:

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

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 external review form.

You must submit the Request for Review by an Independent Review Organization (IRO) Form:

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

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

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 the 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.

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 tell you of 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, or
  - Be much less effective if not started right away (in the case of **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 hours if your request is for an exigent circumstance.

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.

Coordination of benefits

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

The order of benefit determination rules tell you the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms. Payment is made without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Key terms

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

<table>
<tr><td colspan="2">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.</td></tr>
<tr><td>• It includes:</td><td>• 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 policies
• 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 policies
• Medicare or other governmental benefits, as permitted by law</td></tr>
<tr><td>• It does not include:</td><td>• 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
• Accident only coverage
• Specified accident coverage
• School accident-type coverages that cover students for accidents only, including athletic injuries, either on a "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</td></tr>
</table>

	• 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 determine 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 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 accordance 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 a 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's** or **physician's** 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

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 that 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 a 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 plan 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 a 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 contracts is governed by the terms of the contracts. If more than one carrier pays or provides 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 that secondary plan.

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

If you are covered as a:	**Primary plan**	**Secondary plan**
Non-dependent or Dependent	The plan covering you as an employee, policyholder, subscriber, or retired employee.	The plan covering you as a dependent.
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above 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: • **Online:** Log on to your Aetna secure member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans. • **By phone:** Call the toll-free number on your ID card.	
COB rules for dependent children Unless there is a court order stating otherwise, the order of benefits is determined using the following rules that apply.		
Child of: • Parents who are married or living together, whether or not they have ever been married	The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the **calendar year**. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary

If you are covered as a:	Primary plan	Secondary plan
Child of: • Parents separated or divorced or not living together, whether or not they have ever been married • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse's plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse's plan is primary.
Child of: • Parents separated or divorced or not living together, whether or not they have ever been married – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together, whether or not they have ever been married and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Child 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.	
Child of: Parents, who is also covered under a spouse's plan	The plan that has covered the person longer is primary. If 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	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).

If you are covered as a:	Primary plan	Secondary plan
Dependent" paragraph above can determine the order of benefits		
COBRA or state continuation This rule does not apply if: • The other plan 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	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally. This plan will not pay more than it would have paid had it been the primary plan.	

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued
- You voluntarily stop your coverage
- The **group policy** ends
- You are no longer eligible for coverage
- Your employment ends
- You do not make any required **premium** contributions
- We end your coverage for one of the reasons shown in this section
- You choose to become covered under another health benefit plan offered by your employer

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of **illness**, **injury**, sabbatical or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue, until stopped by the policyholder, but not beyond 30 months from the start of your absence
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage will stop on the date that your employment ends.
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage	You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section.
Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 30 months from the start of the absence
Your employment ends because of a leave of absence that is not a medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 1 months from the start of the absence
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence

It is your policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and the policyholder agree in writing to extend them.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- You do not make the required **premium** contribution toward the cost of dependent coverage
- Your coverage ends for any of the reasons listed above, other than:
  - Exhaustion of your overall maximum benefit
  - If you enroll under a group Medicare plan that we offer.
- Your dependent has exhausted the maximum benefit under your medical plan

Important note:
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 us 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 plan coverage ends* section for more information.

Why would we end your and your dependents' coverage?

We may immediately end your coverage if you commit fraud or intentionally misrepresent a material fact when you applied for or obtained coverage. You can refer to the *General provisions-other things you should know - Honest mistakes and intentional deception* section for more information on rescissions.

On the date your coverage ends, we will refund to the policyholder any prepayments 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 *When you disagree – claim decisions and appeals procedures* section of this booklet-certificate.

When will we send you a notice of your coverage ending?

The policyholder will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described in the *Why would we end your coverage?* section above).

Your coverage will end on either the date you stop active work, or the day before the first **premium** contribution due date that occurs after you stop active work.

Coverage will end for you and any dependents on the earlier of the date the group policy terminates or at the end of the period defined by your employer following the date on which you no longer meet the eligibility requirements.

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	• Dependent who has been covered under the plan for at least 1 year • An infant under 1 year of age	3 years
• Retirement of employee		
• Divorce		

When do I receive state continuation information?

The chart below lists who must give the 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 • The amount of **premium** to be charged (in the case of the employee's death or retirement)	Immediately 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 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 policyholder

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 the 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 or could be covered under Medicare
- The date you are covered for similar benefits by another health insurance policy or program
- The date you are covered for similar benefits, whether covered or not covered for those benefits by any arrangement of coverage
- The date you are covered (other than COBRA) for similar benefits by another plan

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

Your coverage may be extended if you or your dependents are totally disabled when coverage ends. Only the medical condition which caused the total disability is covered during your extension.

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

Your dependent is "totally disabled" if that person cannot 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 dependents are no longer totally disabled
- When you become covered by another health benefits plan
- 12 months of coverage

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to ERISA, and according to other federal laws 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 accident and health insurance policy. This document may have amendments, too. Under certain circumstances, we or the policyholder or the law may change your plan at the time of renewal and only in accordance with the group policy. Only **Aetna** may waive a requirement of your plan. No other person – including the policyholder or **provider** – can do this.

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund you or the policyholder any unearned premium.

Legal action

You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the *When you disagree - claim decisions and appeal procedures* section. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations and evaluations

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

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **physicians**, dentists 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 booklet-certificate effective date.

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:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage.

- We will give you 30 days advanced 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 external review organization.

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

In the absence of fraud, any statement made 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.

Assignment of benefits

When you see a **network provider** they will usually bill us directly. When you see an **out-of-network provider,** we may choose to pay you or to pay the **provider** directly. If you assign benefits to such a provider, we will pay them directly.

Notice of claim

We must receive your claim within 20 days (or as soon as reasonably possible) after you get a covered medical service. 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.

Proof of loss

We must receive written proof of loss from 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 for more information.

Grace period

A grace period of 31 days after the **premium** due date will be allowed for the payment of each **premium**.

Premium contribution

This plan requires the policyholder to make **premium** payments. If payments are made through a payroll deduction with the policyholder, the policyholder will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** payments are not made by the end of the grace period. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

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 legal right to get money for your injuries. If you have a legal right to get money from a third party for causing your injuries, then, 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 **injuries**
- You are giving us a right to seek money in your name, from those third parties because of your **injuries**
- You are agreeing to cooperate with us so we can get paid back in full. For example, you'll tell us within 30 days of when you seek money from those third parties for your **injuries** or **illness**. You'll hold any money you receive until we are paid in full, up to the applicable amount noted below. And you'll give us the right to our portion of the money you get, ahead of everyone else.
- You are agreeing to provide us notice of any money you will be receiving before payout, or within 5 days of when you receive the money. Notify us by calling Member Services at the toll-free number on your member ID card.

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 lessor of:

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

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

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

Important note:
If a declaratory judgment action is brought, the court may not award costs or attorney's fees to any party in the action.

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 plan 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 an **eligible health service** that you paid

Reimbursement to Texas Department of Human Services

We will repay the actual costs of medical expenses the Texas Department of Human Services 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 Department of Human Services 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 or 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 Department of Human Services.

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

Intensive Outpatient Program (IOP)

Clinical treatment provided must be **medically necessary** services delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

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

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Texas Medical ET
Issue Date: February 28, 2022