

BENEFIT PLAN

Prepared Exclusively For
Pace University

Open Access Managed Choice

What Your Plan
Covers and How
Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder





Preferred Provider Organization (PPO) Medical Plan

Booklet-certificate

Prepared exclusively for:

Policyholder:	Pace University
Policyholder number:	GP-0181579
	Booklet-Certificate: 2
Group policy effective date:	January 1, 2022
Plan effective date:	January 1, 2022
Plan issue date:	February 28, 2022

Underwritten by Aetna Life Insurance Company

Welcome

Thank You for choosing Aetna.

This is Your Certificate of coverage. It is one of three documents that together describe the benefits covered by Your Aetna plan for in-Network and out-of-Network coverage.

This Certificate will tell You about Your Covered Benefits – what they are and how You get them. If You become insured, this Certificate becomes Your Certificate of coverage under the Group Policy, and it takes the place of all Certificates describing similar coverage that were previously sent to You. The second document is the Schedule of Benefits. It tells You how We share expenses for Eligible Health Services and tells You about limits – like when Your plan covers only a certain number of visits.

The third document is the Group Policy between Aetna Life Insurance Company (“Aetna”) and the policyholder. Ask the policyholder if You have any questions about the Group Policy.

Oh, and each of these documents may have amendments attached to them. They change or add to the documents they’re part of.

Where to next? Flip through the table of contents or try the *Let’s get started!* section right after it. The *Let’s get started!* section gives You a thumbnail sketch of how Your plan works. The more You understand, the more You can get out of your plan.

Welcome to Your Aetna plan for in-Network and out-of-Network coverage.

This Certificate is governed by the laws of New York State.

Table of Contents

	Page
Welcome	
Let's get started!	1
Some notes on how We Use words	1
What Your plan does-providing Covered Benefits	1
How Your plan works-starting and stopping coverage	1
How Your plan works while You are covered in-Network	1
How Your plan works while You are covered out-of-Network	3
How to contact Us for help	3
Your member identification (ID) card	3
Who the plan covers	4
Who is eligible	4
When you can join the plan	4
Who can be on your plan (who can be your dependent)	4
Adding new dependents	5
Special times you and your dependents can join the plan	7
Effective date of coverage	7
Medical Necessity and Preauthorization requirements	8
Medically Necessary; Medical Necessity	8
Preauthorization	8
Case Management	10
Preventive Care and Wellness	11
Physicians and other Health Professionals	15
Hospital and other facility care	17
Emergency services and urgent care	19
Specific conditions	22
Specific therapies and tests	34
Other services	38
Outpatient Prescription Drugs	43
What You need to know about Your outpatient Prescription Drug plan	43
How to access Participating Pharmacies	43
How to access Non-Participating Pharmacies	43
What Outpatient Prescription Drugs are covered	44
Other services	45
How You get an Emergency Prescription filled	48
Where Your Schedule of Benefits fits in	48
What your plan doesn't cover – Exclusions and limitations	51
Outpatient prescription drugs	54
Who provides the care	56
Your PCP	56
Non-Participating Providers	57
Keeping a provider You go to now (continuity of care)	58
What the plan pays and what You pay	58
The general rule	59
Important exception-when your plan pays all	59
Important exceptions - when You pay all	59
Where your Schedule of Benefits fits in	60
When you disagree - Claim Determinations, Grievance and Appeals procedures	61

When coverage ends - Termination	75
Extension of Benefits, Continuation of Coverage and Conversion *	78
General provisions – other things you should know	82
Administrative provisions *	82
Coverage and services	82
Honest mistakes and intentional deception	83
Some other money issues	84
Your health information	85
Glossary	86
Wellness programs	99

Schedule of benefits

Issued with your booklet-certificate

Let's get started!

Here are some basics. First things first – some notes on how we Use words. Then we explain how Your plan works so You can get the most out of Your coverage. But for all the details – and this is very important – You need to read this entire Certificate and the Schedule of Benefits. And if You need help or more information, we tell You how to reach Us.

Some notes on how We Use words

- When We say “You” and “Your”, We mean both You and any covered dependents.
- When We say “Us”, “We”, and “Our”, We mean Aetna.
- Some words appear in capitals. We define them in the *Glossary* section.

Sometimes We Use technical medical language that is familiar to medical Providers.

What Your plan does – providing Covered Benefits

Your plan provides Covered Benefits. These are Eligible Health Services for which Your plan has the obligation to pay.

This plan provides Participating and Non-Participating coverage for medical, vision and pharmacy insurance coverage.

How Your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after You complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when You leave Your job. Family members can lose coverage for many reasons. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean You lose coverage with Us. See the *Special coverage options after Your plan coverage ends* section.

How Your plan works while You are covered in-Network

Your Participating Provider coverage:

- Helps You get and pay for a lot of – but not all – health care services. These are called Eligible Health Services.
- You will pay less cost share when You Use a Participating Provider.

1. Eligible Health Services

Doctor and Hospital services are the foundation for many other services. You'll probably find the preventive care, Emergency Medical Services and Urgent Condition coverage especially important. But the plan won't always cover the services You want. Sometimes it doesn't cover health care services Your doctor will want You to have.

So what are Eligible Health Services? They are health care services that meet these three requirements:

- They are listed in the *Eligible Health Services under Your plan* section.
- They are not carved out in the *What Your plan doesn't cover – Exclusions and limitations* section. (We refer to this section as the “Exclusions” section.)
- They are not beyond any limits in the Schedule of Benefits.

2. Providers

Aetna's Network of doctors, Hospitals and other health care Providers are there to give You the care You need. You can find Participating Providers and see important information about them most easily on Our online Provider Directory. Just log into Your Aetna secure member Website at www.aetna.com.

You may choose a Primary Care Physician (We call that doctor Your PCP) to oversee Your care. Your PCP will provide Your routine care, and send You to other Providers when You need specialized care. You don't have to access care through Your PCP. You may go directly to Participating specialists and Providers for Eligible Health Services. Your plan often will pay a bigger share for Eligible Health Services that You get through Your PCP, so choose a PCP as soon as You can.

For more information about the Network and the role of Your PCP, see the *Who provides the care* section.

3. Paying for Eligible Health Services– the general requirements

There are several general requirements for the plan to pay any part of the expense for an Eligible Health Service. They are:

- The Eligible Health Service is Medically Necessary.
- You get the Eligible Health Service from a Participating or Non-Participating Provider.
- You or Your Provider Preauthorizes the Eligible Health Service when required.

You will find details on Medical Necessity and Preauthorization requirements in the *Medical Necessity and Preauthorization requirements* section.

4. Paying for Eligible Health Services– sharing the expense

Generally Your plan and You will share the expense of Your Eligible Health Services when You meet the general requirements for paying.

But sometimes Your plan will pay the entire expense; and sometimes You will. For more information see the *What the plan pays and what You pay* section, and see the Schedule of Benefits.

5. Disagreements

We know that people sometimes see things differently.

The plan tells You how We will work through Our differences. And if We still disagree, an independent group of experts called an "external review organization" or ERO for short, will make the final decision for Us.

For more information see the *When You disagree - Claim Determinations, Grievance and Appeals procedures* section.

How Your plan works while You are covered out-of-Network

The section above told You how Your plan works while You are covered in-Network. You also have coverage when You want to get Your care from Providers who are not part of the Aetna Network. It's called Non-Participating coverage.

Your Non-Participating coverage:

- Means You can get care from Providers who are not part of the Aetna Network.
- Means You will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement to Us. You are responsible for completing and submitting claim forms for reimbursement of Eligible Health Services that You paid directly to a Provider.
- Means that when You use Non-Participating coverage, it is Your responsibility to start the preauthorization process with Providers.
- Means You will pay a higher cost share when You use a Non-Participating Provider.

You will find details on:

- Precertification requirements in the *Medical Necessity and Preauthorization requirements* section.
- Non-Participating Providers and any exceptions in the *Who provides the care* section. Cost sharing in the *What the plan pays and what You pay* section, and Your Schedule of Benefits.
- Claim information in the *When You disagree - Claim Determinations, Grievance and Appeals procedures* section.

How to contact Us for help

We are here to answer Your questions. You can contact us by logging onto Your Aetna secure member Website at www.aetna.com.

Register for Aetna member website, Our secure Internet access to reliable health information, tools and resources. Aetna member website online tools will make it easier for You to make informed decisions about Your health care, view claims, research care and treatment options, and access information on health and Wellness.

You can also contact Us by:

- Calling Aetna Member Services at the toll-free number on Your ID card
- Writing Us at Aetna Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156

Your member ID card

Your member ID card tells doctors, Hospitals, and other Providers that You are covered by this plan. Show Your ID card each time You get health care from a Provider to help them bill Us correctly and help Us better process their claims.

Remember, only You and Your covered dependents can Use Your member ID card. If You misuse Your card We may end Your coverage.

We will mail You Your ID card. If You haven't received it before You need Eligible Health Services, or if You've lost it, You can print a temporary ID card. Just log into Your Aetna secure member Website at www.aetna.com.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

The policyholder decides and tells us who is eligible for health care coverage.

When you can join the plan

As an employee You can enroll yourself and Your dependents:

- At the end of any waiting period the policyholder requires
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the *Special times You and Your dependents can join the plan* section below)

If You do not enroll yourself and Your dependents when You first qualify for health benefits, You may have to wait until the next annual enrollment period to join.

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

If Your plan includes coverage for dependents, You can enroll the following family members on Your plan. (They are referred to in this booklet-certificate as Your “dependents”.)

- Your legal spouse
- Your domestic partner who meets the rules set by the policyholder and requirements under state law
- The children must be under 26 years of age, and they include:
 - If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child’s adoption. Coverage lasts until the end of the year in which the Child turns 26 years of age. Coverage also includes Children for whom You are a permanent legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children are covered and grandchildren are not covered.
 - Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child’s coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child’s incapacity. We have the right to check whether a Child is and continues to qualify under this section.

- Any unmarried dependent Child who is a full-time student and is on a medical leave from school due to illness. Coverage will continue for a period of twelve months from the last day of attendance at school. The Medical Necessity of a leave of absence from school must be certified by the student's attending physician who is licensed to practice in the state of New York. Written documentation of the illness must be submitted us.
- We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Certificate at any time.

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 -This Certificate covers domestic partners of Subscribers as spouses. If You selected family coverage, Children covered under this Certificate also include the children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:
 - Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6), where such registry exists; or
 - For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
 - The affidavit must be notarized and must contain the following:
 - The partners are both 18 years of age or older and are mentally competent to consent to contract;
 - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
 - The partners have been living together on a continuous basis prior to the date of the application;
 - Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and
 - Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
 - Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
 - A joint bank account;
 - A joint credit card or charge card;
 - Joint obligation on a loan;
 - Status as an authorized signatory on the partner's bank account, credit card or charge card;
 - Joint ownership of holdings or investments;
 - Joint ownership of residence;
 - Joint ownership of real estate other than residence;
 - Listing of both partners as tenants on the lease of the shared residence;

- Shared rental payments of residence (need not be shared 50/50);
 - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
 - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
 - Shared household budget for purposes of receiving government benefits;
 - Status of one (1) as representative payee for the other's government benefits;
 - Joint ownership of major items of personal property (e.g., appliances, furniture);
 - Joint ownership of a motor vehicle;
 - Joint responsibility for child care (e.g., school documents, guardianship);
 - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
 - Execution of wills naming each other as executor and/or beneficiary;
 - Designation as beneficiary under the other's life insurance policy;
 - Designation as beneficiary under the other's retirement benefits account;
 - Mutual grant of durable power of attorney;
 - Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
 - Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
 - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.
- A newborn child - Your newborn child is covered on Your health plan for the first 31 days after birth.
 - If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 31 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 31 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 31 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We; receive notice, provided that You pay any additional Premium when due.
 - 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 the adoption is complete.
 - To keep Your adopted child covered, we must receive Your completed enrollment information within 31 days after the adoption.
 - 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 group 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.

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

Effective date of coverage

Your coverage will be in effect as of the date of You become eligible for health benefits.

Medical Necessity and Preauthorization requirements

The starting point for Covered Benefits under Your plan is whether the services and supplies are eligible health services. See the *Eligible health services under Your plan* and *Exclusions* sections plus the Schedule of Benefits.

Your plan pays for its share of the expense for eligible health services only if the general requirements are met. They are:

- The eligible health service is Medically Necessary.
- You or Your Provider Preauthorizes the eligible health service when required.

This section addresses the Medical Necessity and Preauthorization requirements.

Medically Necessary; Medical Necessity

As We said in the *Let's get started!* section, Medical Necessity is a requirement for You to receive a Covered Benefit under this plan.

The Medical Necessity requirements are stated in the *Glossary* section, where We define "Medically Necessary, Medical Necessity." That is where We also explain what Our medical directors or their Physician designees consider when determining if an Eligible Health Service is Medically Necessary.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>.

Preauthorization

You need pre-approval from Us for some Eligible Health Services. Pre-approval is also called Preauthorization.

In-Network

Your Physician is responsible for obtaining any necessary Preauthorization before You get the care. If Your Physician doesn't get a required Preauthorization, We won't pay the Provider who gives You the care. You won't have to pay either if Your Physician fails to ask Us for Preauthorization. If Your Physician requests Preauthorization and We refuse it, You can still get the care but the plan won't pay for it. You will find details on requirements in the *What the plan pays and what You pay - Important exceptions – when You pay all* section.

Out-of-Network

When You go to a Non-Participating Provider, it is Your responsibility to obtain Preauthorization from Us for any services and supplies on the Preauthorization list. If You do not Preauthorize, Your benefits may be reduced, or the plan may not pay any benefits. Refer to Your Schedule of Benefits for this information. The list of services and supplies requiring Preauthorization appears later in this section. Also, for any Preauthorization benefit reduction that is applied see the Schedule of Benefits *Preauthorization benefit reduction* section.

Preauthorization should be secured within the timeframes specified below. For Emergency Services, Preauthorization is not required, but you should notify us within the timeframes listed below. To obtain Preauthorization, call Us at the telephone number listed on Your ID card. This call must be made:

For non-emergency admissions:	You, Your Physician or the facility will need to call and request Preauthorization at least 14 days before the date You are scheduled to be admitted.
For an Emergency Medical Condition:	If possible, You or Your Physician should call prior to the outpatient care, treatment or procedure or as soon as reasonably possible.
For an Emergency Admission:	You, Your Physician or the facility must call within 48 hours or as soon as reasonably possible after You have been admitted.
For an Urgent Admission:	You, Your Physician or the facility will need to call before You are scheduled to be admitted. An urgent admission is a Hospital admission by a Physician due to the onset of or change in an Illness, the diagnosis of an Illness, or an Injury.
For outpatient non-emergency medical services requiring Preauthorization:	You or Your Physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

We will provide a written notification to You and Your Physician of the Preauthorization decision, where required by state law. If Your Preauthorized services are approved, the approval is valid for 180 days as long as You remain enrolled in the plan.

When You have an inpatient admission to a facility, We will notify You, Your Physician and the facility about Your Preauthorized length of Stay. If Your Physician recommends that Your Stay be extended, additional days will need to be Preauthorized. You, Your Physician, or the facility will need to call Us at the number on Your ID card as soon as reasonably possible, but no later than the final authorized day. We will review and process the request for an extended Stay. You and Your Physician will receive a notification of an approval or denial.

If Preauthorization determines that the Stay or services and supplies are not Covered Benefits, the notification will explain why and how Our decision can be appealed. You or Your Provider may request a review of the Preauthorization decision. See the *When You disagree - Claims Determinations, Grievance and Appeals* section.

What if You don't obtain the required Preauthorization?

If You fail to seek Our Preauthorization or provide notification for benefits subject to this section, We will pay an amount of \$400 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges; cost for services. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

What types of services require Preauthorization?

Preauthorization is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Stays in a hospital	Cosmetic and reconstructive surgery
Stays in a skilled nursing facility	Transcranial magnetic stimulation (TMS)
Stays in a rehabilitation facility	Applied behavior analysis
Stays in a hospice facility	Partial Hospitalization Treatment – Mental Disorder and Substance Abuse diagnoses
Stays in a residential treatment facility for treatment of mental disorders and substance abuse	
Bariatric surgery (obesity)	

Prescription drugs are covered under the medical plan when they are given to you by Your doctor or health care facility. The following information applies to these Prescription drugs:

For certain drugs, Your Provider needs to get approval from Us before We will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are Medically Necessary.

Step Therapy is a type of Preauthorization where We require You to first try certain drugs to treat Your medical condition before We will cover another drug for that condition.

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

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

Case Management

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Certificate; Contract; Policy. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

Eligible Health Services under Your plan

The information in this section is the first step to understanding Your plan's Eligible Health Services.

Your plan covers many kinds of health care services and supplies, such as Physician care and Hospital Stays. But sometimes those services are not covered at all or are covered only up to a limit.

For example,

- Physician care generally is covered but Physician care for Cosmetic surgery is never covered. This is an exception (Exclusion).
- Home Health Care is generally covered but it is a Covered Benefit only up to a set number of visits a year. This is a limitation.

You can find out about these exceptions in the *Exclusions* section, and about the limitations in the Schedule of Benefits.

Important note:

Sex-specific Eligible Health Services are covered when medically appropriate, regardless of identified gender.

We've grouped the health care services below to make it easier for You to find what You're looking for.

Preventive Care and Wellness

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care

We cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”), or if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (“ACIP”).

However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on Your ID card or logging on to Your secure member website at www.aetna.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an “A” or “B” rating from USPSTF, and immunizations recommended by ACIP.

Well-Baby and Well-Child Care

We cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. If the schedule of well-child visits referenced above permits one well-child visit per Calendar Year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Adult Annual Physical Examinations

We cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

Examples of items or services with an “A” or “B” rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our website, log on to Your Aetna secure member website at www.aetna.com, or will be mailed to You upon request.

You are eligible for a physical examination once every Calendar Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

Adult Immunizations

We cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

Well-Woman Examinations

We cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating the cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at www.aetna.com, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

This plan includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. This benefit is not subject to Deductibles, Copayments and/or Coinsurance when provided in accordance with HRSA guidelines and when provided by a Participating Provider.

We also cover screening for diabetes after pregnancy for women with a history of diabetes during pregnancy and screening for urinary incontinence.

Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer

We cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We cover mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Family Planning and Reproductive Health Services

We cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise covered under the Prescription Drug coverage section of this Certificate, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

We also cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not cover services related to the reversal of elective sterilizations.

Bone Mineral Density Measurements or Testing

We cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

Screening for Prostate Cancer

We cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Additional Preventive Screening and Counseling Services

We cover screening and counseling by Your Health Professional for some additional conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

- **Obesity and/or healthy diet counseling**

Eligible Health Services include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**

Eligible Health Services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

- **Use of tobacco products**

Eligible Health Services include the following screening and counseling services to help You to stop the use of tobacco products:

- Preventive counseling visits
- Treatment visits
- Class visits
- Tobacco cessation prescription and over-the-counter drugs
 - Eligible Health Services include FDA- approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing.

Tobacco product means a substance containing tobacco or nicotine such as:

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**

Eligible Health Services include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**

Eligible Health Services include the counseling and evaluation services to help You assess whether or not You are at increased risk for breast and ovarian cancer.

Important note:

Sex-specific eligible health services are covered when medically appropriate, regardless of identified gender.

Physicians and other Health Professionals

Physician services

Eligible Health Services include services by Your Physician to treat an Illness or Injury. You can get those services:

- At the Physician's office
- In Your home
- In a Hospital
- From any other inpatient or outpatient facility
- By way of Telemedicine

Important note:

Your policy covers Telemedicine only when you get your consult through a Provider that has contracted with Aetna to offer these services.

All in person office visits covered with a Behavioral Health Provider are also covered if you use Telemedicine instead.

Telemedicine may have different cost sharing. See the Schedule of Benefits for more information.

Other services and supplies that Your Physician may provide:

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

Alternatives to Physician office visits

Walk-In Clinic

Eligible Health Services include health care services provided at Walk-In Clinics for:

- Unscheduled, non-medical emergency Illnesses and Injuries
- The administration of immunizations administered within the scope of the clinic's license

Delivery of Covered Services Using Telehealth

If Your Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

Hospital and other facility care

Hospital care

We Cover inpatient Hospital services for acute care or treatment given or ordered by a Health Care Professional for an Illness, Injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Certificate apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

Observation Services

We cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

Inpatient Medical Services

We cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

Inpatient Stay for Maternity Care

We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. The care also includes coverage for the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Certificate that apply to home care benefits.

Inpatient Stay for Mastectomy Care

We cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

End of Life Care

If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will cover acute care provided in a licensed Article 28 Facility or acute care facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the facility. If We disagree with Your admission to the facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will cover and reimburse the facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse acute care at the facility's current Medicare acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare acute care rate.

Alternatives to Hospital Stays

Outpatient surgery and physician surgical services

We cover services provided and supplies used in connection with outpatient Surgery performed in a Surgery Center or a Hospital's outpatient department.

Important note:

Some Surgeries can be done safely in a Physician's office. For those Surgeries, your plan will pay only for Physician and not for a separate fee for facilities.

Home health care

We cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited the visits as shown on your Schedule of Benefits. Each visit by a member of the Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is considered one visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

Hospice care

Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. We also cover for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not cover: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

Skilled Nursing Facility

We cover inpatient Skilled Nursing Facility care.

The types of Skilled Nursing Facility care services that are eligible for coverage include:

- Room and Board, up to the Semi-Private Room rate
- Services and supplies that are provided during your Stay in a Skilled Nursing Facility

Emergency services and Urgent Care

In case of a medical emergency

When you experience an Emergency Medical Condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your Physician, PCP but only if a delay will not harm your health.

Emergency Services

We cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an “Emergency Condition” to mean: A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also cover Emergency Services to treat Your Emergency Condition worldwide. However, We will cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

Hospital Emergency Department Visits.

In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department.** If You are uncertain whether a Hospital emergency department is the most appropriate place to receive care, You can call Us before You seek treatment. Our Medical Management Coordinators are available 24 hours a day, 7 days a week. Your Coordinator will direct You to the emergency department of a Hospital or other appropriate Facility.

We do not Cover follow-up care or routine care provided in a Hospital emergency department.

You should contact Us to make sure You receive the appropriate follow-up care.

Emergency Hospital Admissions.

In the event that You are Admitted to the Hospital, You or someone on Your behalf must notify Us at the number on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

We Cover inpatient Hospital services at a non-participating Hospital at the in-network Cost-Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital , unless We authorize continued treatment at the non-participating Hospital. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and work with You to and arrange the transfer. Any inpatient Hospital services received from a non-participating Hospital after We have notified You and offered assistance in arranging; arranged for a transfer to a participating Hospital will not be Covered.

Payments Relating to Emergency Services Rendered.

The amount We pay a Non-Participating Provider for Emergency Services will be the amount We have negotiated with the Non-Participating Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency Service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge and will be at least the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare.

If a dispute involving a payment for physician services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for physician services.

You are responsible for any in-network Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance.

Non-emergency condition

If you go to an emergency room for what is not an Emergency Medical Condition, the plan may not cover Your expenses. See the Schedule of Benefits and the *exception- Emergency services and urgent care and Preauthorization benefit reduction* sections for specific plan details.

In case of an Urgent Condition

Urgent Condition

If You need care for an Urgent Condition, You should first seek care through Your Physician, PCP. If Your Physician, PCP is not reasonably available to provide services, You may access urgent care from an Urgent Care Facility. If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions or visit an Urgent Care Center. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

Non-urgent care

If You go to an Urgent Care Facility for what is not an Urgent Condition, the plan may not cover Your expenses. See the *exception –Emergency services and urgent care and Precertification benefit reduction* sections and the schedule of benefits for specific plan details.

Specific conditions

Autism spectrum disorder

We cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, “autism spectrum disorder” means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

- **Screening and Diagnosis.** We cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
- **Assistive Communication Devices.** We cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only cover devices that generally are not useful to a person in the absence of a communication impairment. We do not cover items, such as, but not limited to, laptops, desktop, or tablet computers. We cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

We cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, We cover one repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We do not cover delivery or service charges or routine maintenance.

- **Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Provider. “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

- **Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.
- **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.
- **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.
- **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Certificate for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Certificate for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-Covered Services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities.

Birthing center

We cover prenatal and postpartum care and obstetrical services from Your Provider. After Your child is born, Eligible Health Services include:

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Diabetic equipment, supplies and education

We cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

Equipment and Supplies

We cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:

- Acetone reagent strips
- Acetone reagent tablets
- Alcohol or peroxide by the pint
- Alcohol wipes
- All insulin preparations
- Automatic blood lance kit
- Blood glucose kit
- Blood glucose strips (test or reagent)
- Blood glucose monitor with or without special features for visually impaired,
- Blood glucose kit control solutions, and strips for home blood glucose monitor
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose reagent strips
- Glucose reagent tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

Self-Management Education

Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

Limitations

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

Family planning services – other

We cover certain family planning services provided by Your Physician such as:

- Voluntary sterilization for males
- Therapeutic abortions including abortions in cases of rape, incest or fetal malformation (i.e., medically necessary abortions). We Cover elective abortions for one(1) procedure per Member per Calendar Year.

Maternity and related newborn care

We cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We cover prenatal care (including one visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for coverage of inpatient maternity care.

We cover the breastfeeding support, counseling and supplies, including cost of renting or the purchase of one breast pump per pregnancy for the duration of breast feeding.

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

Mental health treatment

Inpatient Services

We cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. Coverage for inpatient services for mental health care is limited to facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient facility;
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- A comprehensive psychiatric emergency program or other facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health; and, in other states, to similarly licensed or certified facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

We also cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at facilities that provide residential treatment, including Room and Board charges. Coverage for residential treatment services is limited to facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to facilities that are licensed or certified to provide the same level of treatment. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

Outpatient Services

We cover outpatient mental health care services, including but not limited to partial hospitalization program services and Intensive Outpatient Program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; a psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

Limitations/Terms of Coverage

We do not cover:

- Benefits or services deemed to be Cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for Youth operated by the New York State Office of Children and Family Services; or
- Services solely because they are ordered by a court.

Please refer to the Schedule of Benefits section of this Certificate for Cost Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

Important note:

Your plan covers Telemedicine only when you get your telephone or internet-based consult through an authorized internet service vendor who conducts Telemedicine consultations that has contracted with Aetna to offer these services. Provider search tells you who those are.

Substance Abuse

Inpatient Services

We cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder. This includes coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs.

We also cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at facilities that provide residential treatment, including Room and Board charges. Coverage for residential treatment services is limited to OASAS-certified facilities defined in 14 NYCRR 819.2(a)(1), 820.3(a)(1) and (2) and to services provided in such facilities in accordance with 14 NYCRR Parts 817 and 819; and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

Outpatient Services

We cover outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, counseling, and medication assisted treatment. Such coverage is limited to facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use disorder or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute Detoxification stage of treatment or during stages of rehabilitation.

Additional Family Counseling. We also cover up to 20 outpatient visits per Calendar Year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use disorder; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use and/or dependency. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

Please refer to the Schedule of Benefits section of this Certificate for Cost Sharing requirement, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

Obesity (bariatric) surgery

We cover obesity surgery, which is also known as “weight loss surgery.” Obesity surgery is a type of procedure performed on people who are Morbidly Obese, for the purpose of losing weight.

Obesity is typically diagnosed based on Your Body Mass Index (BMI). To determine whether You qualify for obesity surgery, Your doctor will consider Your BMI and any other condition or conditions You may have. Your doctor will request approval from Us in advance of Your Obesity surgery. We will cover charges made by a Network Provider for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient Prescription Drug benefits included under the *Outpatient Prescription Drugs* section

Health care services include one Obesity surgical procedure. However, Eligible Health Services also include a multi-stage procedure when planned and approved by Us. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

You may go to any of Our Network facilities that perform Obesity surgeries.

Oral Surgery

We cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental Injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the Injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

Reconstructive Breast Surgery

We cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes:

- All stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate
- We also cover implanted breast prostheses following a mastectomy or partial mastectomy.

Reconstructive Surgery (Other than Breast Reconstruction after a Mastectomy) and supplies

Eligible Health Services include reconstructive Surgery by Your Provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your Surgery corrects an accidental Injury that happened no more than 24 months before Your Surgery. For a covered person under age 18, the time period for coverage may be extended through age 18. Injuries that occur during Surgical Procedures or medical treatments are not considered accidental Injuries, even if unplanned or unexpected.
- 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.

Transplant services

We cover organ transplant services provided by a Physician and Hospital.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as Institutes of Excellence™ (IOE) facilities in your provider directory.

Important note:

- If there is no IOE facility for your transplant type in your network, the National Medical Excellence Program® (NME) will arrange for and coordinate your care at an IOE facility in another one of our networks. If you don't get your transplant services at the IOE facility we designate, your cost share will be higher.
- Many pre and post transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the National Medical Excellence Program® (NME), all medical services must be managed through the NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the eligible health service is not directly related to your transplant.

Treatment of infertility

We cover services for the diagnosis and treatment (surgical and medical) of Infertility when such Infertility is the result of malformation, disease or dysfunction. Such coverage is available as follows:

Basic Infertility Services

Basic Infertility services will be provided to a Member who is an appropriate candidate for Infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York.

Basic Infertility services include:

- Initial evaluation;
- Semen analysis;
- Laboratory evaluation;
- Evaluation of ovulatory function;
- Postcoital test;
- Endometrial biopsy;
- Pelvic ultra sound;
- Hysterosalpingogram;
- Sono-hystogram;
- Testis biopsy;
- Blood tests; and
- Medically appropriate treatment of ovulatory dysfunction.

Additional tests may be covered if the tests are determined to be Medically Necessary.

Comprehensive Infertility Services

If the basic Infertility services do not result in increased fertility, We cover comprehensive Infertility services.

Comprehensive Infertility services include:

- Ovulation induction and monitoring;
- Pelvic ultra sound;
- Artificial insemination;
- Hysteroscopy;
- Laparoscopy; and
- Laparotomy.

The first step to using Your comprehensive Infertility health care services is enrolling with Our National Infertility Unit (NIU). To enroll You can reach Our dedicated NIU at 1-800-575-5999.

Infertility services

You are eligible for Infertility services if:

- There exists a condition that:
 - Is demonstrated to cause the disease of Infertility.
 - Has been recognized by your Physician or Infertility Specialist and documented in your or your partner's medical records.
- You have not had a voluntary sterilization, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.

- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have met the requirement for the number of months trying to conceive through egg and sperm contact.

Our NIU is here to help You. It is staffed by a dedicated team of registered nurses and Infertility coordinators with expertise in all areas of Infertility who can help:

- Enroll in the Infertility program.
- Assist You with precertification of Eligible Health Services.
- Coordinate precertification for comprehensive Infertility when these services are Eligible Health Services.
- Evaluate Your medical records to determine whether comprehensive Infertility services are reasonably likely to result in success.
- Determine whether comprehensive Infertility services are Eligible Health Services.

Your Provider will request approval from Us in advance for Your Infertility services. We will cover charges made by a network Infertility Specialist for the following Infertility services:

- Ovulation induction cycle(s) with menotropins.
- Intrauterine insemination.

A “cycle” is an attempt at ovulation induction or intrauterine insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

Advanced reproductive technology

Advanced Infertility Services

We Cover advanced infertility services.

Advanced infertility services include:

- In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs for an ovum donor or donor sperm;
- Sperm storage costs; and
- Cryopreservation and storage of embryos.

Exclusions and Limitations

We do not Cover:

- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for members acting as surrogate mothers); Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

You are eligible for ART services if:

- You are covered under this plan as an employee or as a covered dependent who is the employee's legal spouse, civil union partner, or domestic partner, referred to as "Your partner". Dependent children are covered under this plan for ART services only in the case of fertility preservation due to planned cancer treatment that will render the individual infertile.
- There exists a condition that:
 - Is demonstrated to cause the disease of infertility.
 - Has been recognized by Your physician or infertility specialist and documented in Your or Your partner's medical records.
- You have not had a voluntary sterilization (tubal ligation, hysterectomy and vasectomy) with or without surgical reversal, regardless of post reversal results.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have exhausted the comprehensive Infertility services benefits or have clinical need to move on to ART procedures.
- You have met the requirement for the number of months trying to conceive through egg and sperm contact.

Fertility preservation

Only cancer patients are eligible for fertility preservation. Fertility preservation involves the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use. You are eligible for fertility preservation only when You:

- Are believed to be fertile
- Have planned services that will result in Infertility such as:
 - Chemotherapy
 - Pelvic radiotherapy
 - Other gonadotoxic therapies
 - Ovarian or testicular removal

Along with the eligibility requirements above, You are eligible for fertility preservation benefits if, for example:

- You, Your partner or dependent child are planning treatment that is demonstrated to result in Infertility. Planned treatments include:
 - Bilateral orchiectomy (removal of both testicles)
 - Bilateral oophorectomy (removal of both ovaries)
 - Hysterectomy (removal of the uterus)
 - Chemotherapy or radiation therapy that is established in medical literature to result in Infertility

Eligible Health Services for fertility preservation will be paid on the same basis as other ART services benefits for individuals who are Infertile and not diagnosed with cancer.

Our National Infertility Unit (NIU) is here to help You. It is staffed by a dedicated team of registered nurses and Infertility coordinators with expertise in all areas of Infertility who can help:

- Enroll in the Infertility program.
- Assist You with Precertification of Eligible Health Services.
- Coordinate Precertification for ART services and fertility preservation services when these services are Eligible Health Services. Your Provider should obtain Precertification for fertility preservation services through the NIU either directly or through a reproductive endocrinologist.
- Evaluate Your medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.
- Determine whether ART services and fertility preservation services are Eligible Health Services.
- Case manage for the provision of ART services and fertility preservation services for an eligible covered person.

Your Provider will request approval from Us in advance for Your ART services and fertility preservation services. We will cover charges made by a network ART Specialist for the following ART services:

- Any combination of the following ART services:
 - In vitro fertilization (IVF)*
 - Zygote intrafallopian transfer (ZIFT)
 - Gamete intrafallopian transfer (GIFT)
 - Cryopreserved embryo transfers (Frozen Embryo Transfer (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Charges associated with Your care when using a gestational carrier including egg retrieval and culture and fertilization of Your eggs that will be transferred into a gestational carrier. The embryo transfer itself is not covered. *See the What Your plan doesn't cover – some eligible health services exceptions section.*

- Charges associated with Your care when You will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into You.
- Charges associated with obtaining sperm from Your partner when they are covered under this plan for ART services.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.

A “cycle” is an attempt at a particular type of Infertility treatment (e.g., GIFT, ZIFT, cryopreserved embryo transfers). The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

*Note: In some plans with limits on the number of cycles of IVF covered, “one” cycle of IVF may be considered as one elective single embryo transfer (ESET) cycle followed consecutively by a frozen single embryo transfer cycle. This cycle definition applies only to individuals who meet the criteria for ESET, as determined by our NIU and for whom the initial ESET cycle did not result in a documented fetal heartbeat. Eligible Health Services for ESET will be paid on the same basis as any other ART services benefit.

Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

We cover complex imaging services by a Provider, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including Positron emission tomography (PET) scans
- Other outpatient diagnostic imaging service where the billed charge exceeds \$500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

We cover diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when You get them from a licensed radiological facility or lab.

Chemotherapy

Eligible Health Services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, Your Hospital benefit covers the initial dose of chemotherapy after a cancer diagnosis during a Hospital Stay. Chemotherapy may be administered by injection or infusion.

Outpatient infusion therapy

We cover infusion therapy You receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a Hospital
- A Physician in the office
- A home care Provider in Your home

You can access the list of preferred infusion locations by contacting Member Services by logging onto Your Aetna secure member website at <https://www.aetna.com> or calling the number on Your ID card.

Infusion therapy is the parenteral (e.g. intravenous) administration of prescribed medications or solutions.

Certain infused medications may be covered under the outpatient Prescription Drug coverage. You can access the list of Specialty Prescription Drugs by contacting Member Services or by logging onto Your Aetna secure member website at <https://www.aetna.com> or calling the number on Your ID card to determine if coverage is under the outpatient Prescription Drug benefit or this Certificate.

When Infusion therapy services and supplies are provided in Your home, they will not count toward any applicable Home Health Care maximums.

Specialty Prescription Drugs

We cover Specialty Prescription Drugs when they are:

- Purchased by Your Provider, and
- Injected or infused by Your Provider in an outpatient setting such as:
 - A free-standing outpatient facility
 - The outpatient department of a Hospital
 - A Physician in the office
 - A home care Provider in Your home
- And, listed on Our Specialty Prescription Drug list as covered under this booklet-Certificate.

You can access the list of Specialty Prescription Drugs by contacting Member Services by logging onto Your Aetna secure member website at <https://www.aetna.com> or calling the number on Your ID card. to determine if coverage is under the outpatient Prescription drug benefit or this Certificate.

Certain injected and infused medications may be covered under the outpatient Prescription Drug coverage. You can access the list of Specialty Prescription Drugs by contacting Member Services or by logging onto Your Aetna secure member website at <https://www.aetna.com> or calling the number on Your ID card to determine if coverage is under the outpatient Prescription Drug benefit or this Certificate.

When injectable or infused services and supplies are provided in Your home, they will not count toward any applicable Home Health Care maximums.

Outpatient radiation therapy

Eligible Health Services include the following radiology services provided by a Health Professional:

- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Preadmission Testing

We cover preadmission testing ordered by Your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven days of the tests; and
- the patient is physically present at the Hospital for the tests.

Short-term cardiac and pulmonary rehabilitation services

We cover the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

We cover cardiac rehabilitation services You receive at a Hospital, Skilled Nursing Facility or Physician's office, but only if those services are part of a treatment plan determined by Your risk level and ordered by Your Physician.

Pulmonary rehabilitation

We cover pulmonary rehabilitation services as part Your inpatient Hospital Stay if it is part of a treatment plan ordered by Your Physician.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a Hospital, Skilled Nursing Facility, or Physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by Your Physician.

Short-term rehabilitation services

Short-term rehabilitation services help You restore or develop skills and functioning for daily living.

Eligible Health Services include short-term rehabilitation services Your Physician prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A Hospital, skilled Nursing Facility, or Hospice Facility
- A Home Health Care Agency
- A Physician

Short-term rehabilitation services have to follow a specific treatment plan, ordered by Your Physician.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible Health Services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute Illness, Injury or Surgical Procedure.
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
 - Significantly improve, develop or restore physical functions You lost as a result of an acute Illness, Injury or Surgical Procedure, or
 - Relearn skills so You can significantly improve Your ability to perform the activities of daily living on Your own.

- Speech therapy, but only if it is expected to:
 - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute illness, injury or surgical procedure, or
 - Improve delays in speech function development caused by a gross anatomical defect present at birth.

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
 - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
 - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Habilitation therapy services for autism spectrum disorder treatment

Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

Eligible Health Services include habilitation therapy services your physician prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A hospital, skilled nursing facility, or hospice facility
- A home health care agency
- A physician

Habilitation therapy services have to follow a specific treatment plan, ordered by your physician.

Outpatient physical, occupational, and speech therapy

Eligible Health Services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to develop any impaired function
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development
(Speech function is the ability to express thoughts, speak words and form sentences.)

Telemedicine Program

We cover online internet consultations between you and providers who participate in our telemedicine program for medical conditions that are not an emergency condition.

Other services

Acupuncture

We cover the treatment by the use of acupuncture (manual or electroacupuncture) provided by Your Physician, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure

Ambulance service and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and Ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

Emergency Ambulance Transportation

We cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an Ambulance service.

“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an Ambulance service issued a certificate under the New York Public Health Law. We will, however, only cover transportation to a Hospital provided by such an Ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An Ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance. In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable.

In addition to Pre-Hospital Emergency Medical Services, We also cover emergency Ambulance transportation by a licensed Ambulance service (either ground, water or air Ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency Ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

Non-Emergency Ambulance Transportation

We cover non-emergency Ambulance transportation by a licensed service (either ground or air Ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective acute care Facility; or
- From an acute care Facility to a sub-acute setting.

Limitations/Terms of Coverage

- We do not cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not cover non-Ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air Ambulance related to an Emergency Condition or air Ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land Ambulance is not appropriate; and Your medical condition requires immediate and rapid Ambulance transportation that cannot be provided by land Ambulance; and one (1) of the following is met:
 - The point of pick-up is inaccessible by land vehicle; or
 - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

Ambulatory Surgical Center Services

We cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed, when provided by a Participating Provider.

Chiropractic care

We cover chiropractic care when performed by a Doctor of Chiropractic (“chiropractor”) or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be covered in accordance with the terms and conditions of this Certificate.

Clinical trials

We cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Certificate.

We do not cover:

- the costs of the investigational drugs or devices;
- the costs of non-health services required for You to receive the treatment;
- the costs of managing the research; or
- the costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

An “approved clinical trial” means a phase I, II, III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

Dialysis coverage

We cover dialysis treatments of an acute or chronic kidney ailment.

We also Cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than 10 dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

Durable Medical Equipment (DME)

Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of Durable Medical Equipment.

Cochlear Implants.

We Cover bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Nutritional supplements

Eligible Health Services include formula and low protein modified food products ordered by a Physician for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

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.

Ostomy Equipment and Supplies

We Cover ostomy equipment and supplies prescribed or recommended by a Health Care Professional.

Prescription Drugs for Use in the Office and Outpatient Facilities

We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider’s office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate.

Prosthetic devices

External Prosthetic Devices

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

We do not Cover orthotics (e.g., shoe inserts).

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We Cover the cost of one (1) prosthetic device, per limb, per lifetime. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

Internal Prosthetic Devices

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

Second Opinions

Second Cancer Opinion. We cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-Network basis when Your attending Physician provides a written Referral to a Non-participating Specialist.

Second Surgical Opinion. We cover a second surgical opinion by a qualified Physician on the need for Surgery.

Second Opinions in Other Cases. There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that We designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will Preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

Vision care

Routine vision exams

Eligible Health Services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

Outpatient Prescription Drugs

What You need to know about Your outpatient Prescription Drug plan

Read this section carefully so that You know:

- How to access Participating Pharmacies
- How to access Non-Participating Pharmacies
- Eligible Health Services under Your plan
- What outpatient Prescription Drugs are covered
- Other services
- How You get an emergency Prescription filled
- Where Your Schedule of Benefits fits in
- What Precertification requirements apply
- How do I request a medical exception
- What Your plan doesn't cover – some Eligible Health Service Exclusions
- How You share the cost of Your outpatient Prescription Drugs

Some Prescription Drugs may not be covered or coverage may be limited. This does not keep You from getting Prescription Drugs that are not Covered Benefits. You can still fill Your Prescription, but You have to pay for it Yourself. For more information see the *Where Your Schedule of Benefits fits in* section, and see the Schedule of Benefits.

A Pharmacy may refuse to fill a Prescription order or refill when in the professional judgment of the pharmacist the Prescription should not be filled.

How to access Participating Pharmacies

How do You find a Participating Pharmacy?

You can find a Participating Pharmacy in two ways:

- **Online:** By logging onto Your secure member website at www.aetna.com.
- **By phone:** Call the toll-free Member Services number on Your member ID card. During regular business hours, a Member Services representative can assist You. Our automated telephone assistant can give You this information 24 hours a day.

You may go to any Participating Pharmacies. Pharmacies include Network Retail, Mail Order and Specialty Pharmacies.

How to access Non-Participating Pharmacies

You can directly access a Non-Participating Pharmacy to get covered outpatient Prescription Drugs.

When you use an Non-Participating Pharmacy, you pay your in-network coinsurance or Copayment then you pay any remaining Deductible and then you pay your out-of-network Coinsurance. If You use an Non-Participating Pharmacy to obtain outpatient Prescription Drugs, You are subject to a higher out-of-pocket expense and are responsible for:

- Paying Your Participating outpatient Prescription Drug cost share
- Paying Your Non-Participating outpatient Prescription Drug Deductible
- Your Non-Participating Coinsurance
- Any charges over Our Recognized Charge
- Submitting Your own claims

Eligible Health Services under Your plan:

What does your outpatient prescription drug plan cover?

Any Pharmacy service that meets these three requirements:

- They are listed in the *Eligible Health Services under Your plan* section.
- They are not carved out in the *Exclusions* section.
- They are not beyond any limits in the Schedule of Benefits

Your plan benefits are covered when You follow the plan's general rules:

- You need a Prescription from Your Prescriber.
- Your drug needs to be Medically Necessary for Your Illness or Injury. See the *Medical Necessity and Precertification* requirements section.
- You need to show Your ID card to the Pharmacy when You get a Prescription filled.

Your outpatient Prescription Drug plan is based on drugs in the drug guide. The drug guide includes both Brand-Name Prescription Drugs and Generic Prescription Drugs. Your out-of-pocket costs may be higher if Your Prescriber prescribes a Prescription Drug not listed in the drug guide.

Generic Prescription Drugs may be substituted by Your pharmacist for Brand-Name Prescription Drugs. Your out-of-pocket costs may be less if You use a Generic Prescription Drug when available.

Prescription drugs covered by this plan are subject to misuse, waste, and/or abuse utilization review by Us, Your Provider, and/or Your Participating Pharmacy. The outcome of this review may include: limiting coverage of the applicable drug(s) to one prescribing Provider and/or one Participating Pharmacy, limiting the quantity, dosage, day supply, requiring a partial fill or denial of coverage.

What Outpatient Prescription Drugs are covered

Your Prescriber may give You a Prescription in different ways, including:

- Writing out a Prescription that You then take to a Participating Pharmacy.
- Calling or e-mailing a Participating Pharmacy to order the medication.
- Submitting Your Prescription electronically.

Once You receive a Prescription from Your Prescriber, You may fill the Prescription at a Participating Retail, Mail Order or Specialty Pharmacy.

Retail Pharmacy

Generally, Retail Pharmacies may be used for up to a 30 day supply of Prescription Drugs except for contraceptive drugs or devices. You should show Your ID card to the Participating Pharmacy every time You get a Prescription filled. The Participating Pharmacy will calculate Your claim online. You will pay any cost sharing directly to the Participating Pharmacy.

You do not have to complete or submit claim forms. The Participating Pharmacy will take care of claim submission.

Mail Order Pharmacy

Generally, the drugs available through mail order are maintenance drugs that You take on a regular basis for a chronic or long-term medical condition. These drugs may be ordered through mail order after an initial 30 day supply with the exception of contraceptive drugs or devices which are available for an initial three month supply.

Outpatient Prescription Drugs are covered when dispensed by a Participating Mail Order Pharmacy. Each Prescription is limited to a maximum 90 day supply. Prescriptions for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a Participating Mail Order Pharmacy.

Specialty Pharmacy

Specialty Prescription Drugs often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Each Prescription is limited to a maximum 30 day supply. You can access the list of Specialty Care Prescription Drugs by logging onto Your secure member website at www.aetna.com or calling the number on Your ID card.

Specialty Prescription Drugs are covered when dispensed through a network Specialty Pharmacy.

All Specialty Prescription Drugs fills after the initial fill must be filled at a Participating Specialty Pharmacy except for urgent situations.

Other services

Preventive Contraceptives

For females who are able to reproduce, your outpatient Prescription Drug plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing. Your outpatient Prescription Drug plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs by logging onto Your secure member website at www.aetna.com or calling the number on your ID card.

We cover over-the-counter (OTC) and Generic Prescription Drugs and devices for each of the methods identified by the FDA at no cost share. If a Generic Prescription Drug or device is not available for a certain method, you may obtain certain Brand-Name Prescription Drug for that method at no cost share.

You may have an initial three-month supply of a contraceptive drug or device dispensed to You. For subsequent dispensing of the same contraceptive drug or device, You may have the entire prescribed supply (of up to 12 months) of the contraceptive drug or device dispensed at the same time. Contraceptive drugs and devices are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Important note: You may qualify for a medical exception. If Your Prescriber documents a medical exception and submits the exception to Us, certain FDA-approved Brand-Name or non-formulary contraceptives may also be covered as preventive.

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
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs

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

Enteral formulas

We cover non-Prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastro-esophageal reflux with failure to thrive; gastro-esophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.

Eye drops (early refills)

For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited refill is the amount that applies to each Prescription or refill as shown in the Schedule of Benefits section of this Certificate.

Immunizations

Eligible health services include preventive immunizations as required by the ACA guidelines when administered a Participating Pharmacy. You should call the number on your ID card to find a Participating Pharmacy. You should contact the Pharmacy for availability, as not all Pharmacies will stock all available vaccines.

Infertility drugs

We cover injectable, self-injectable and oral synthetic ovulation stimulant Prescription Drugs used primarily for the purpose of treating the underlying cause of Infertility.

Off-label use

U.S. Food and Drug Administration (FDA) approved Prescription Drugs may be covered when the off-label use of the drug has not been approved by the FDA for your condition. Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your condition in one of the following standard compendia:
 - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information)
 - Thomson Micromedex DrugDex System (DrugDex)
 - Clinical Pharmacology (Gold Standard, Inc.)
 - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium; or

- Use for your condition 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 is equal to the dosage for the same condition 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 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.

Over-the-counter drugs

Eligible Health Services include certain over-the-counter medications, as determined by the plan. Coverage of the selected over-the-counter medications requires a Prescription. You can access the list by logging onto Your secure member website at www.aetna.com.

Preventive care drugs and supplements

We cover preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the ACA guidelines when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing.

Risk reducing breast cancer Prescription drugs

We cover Prescription Drugs when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing for a woman who is at:

- Increased risk for breast cancer, and
- Low risk for adverse medication side effects

Sexual dysfunction/enhancement

We cover Prescription Drugs for the treatment of sexual dysfunction/enhancement. For the most up-to-date information on dosing, call the toll-free number on your ID card.

Tobacco cessation prescription and over-the-counter drugs

Eligible Health Services include FDA-approved Prescription Drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing.

How You get an emergency Prescription filled

You may not have access to a Participating Pharmacy in an Emergency or Urgent Care situation, or You may be traveling outside of the plan's Service Area. If you must fill a Prescription in either situation, We will reimburse You as shown in the table below.

Type of Pharmacy	Your cost share
Participating Pharmacy	<ul style="list-style-type: none">You pay the Copayment.
Non-Participating Pharmacy	<ul style="list-style-type: none">You pay the Pharmacy directly for the cost of the Prescription. Then you fill out and send a Prescription Drug refund form to Us, including all itemized Pharmacy receipts.Coverage is limited to items obtained in connection with covered Emergency and out-of-area Urgent Care services.Submission of a claim doesn't guarantee payment. If Your claim is approved, You will be reimbursed the cost of Your Prescription less your Copayment/Coinsurance.

Emergency Supply of Prescription Drugs for Substance Use Disorder Treatment

If You have an Emergency Condition, You may immediately access, without Preauthorization, a five (5) day emergency supply of a Prescription Drug for the treatment of a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. If You have a Copayment, it will be the same Copayment that would apply to a 30-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the 30-day period in which You received the emergency supply, You will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.

In this paragraph, "Emergency Condition" means a substance use disorder condition that manifests itself by Acute symptoms of sufficient severity, including severe pain or the expectation of severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Where Your Schedule of Benefits fits in

You are responsible for paying Your part of the cost sharing. The Schedule of Benefits shows any benefit limitations and any out-of-pocket costs You are responsible for. Keep in mind that You are responsible for costs not covered under this plan.

Your Prescription Drug costs are based on:

- The type of Prescription Drug you're prescribed
- Where You fill Your Prescription

The plan may in certain circumstances make some Brand-Name Prescription Drugs available to You at the Generic Prescription Drug Copayment level.

How Your outpatient Prescription Drug Deductible works

Your outpatient Prescription Drug Deductible is the amount You need to pay for outpatient Prescription Drug Eligible Health Services before Your plan begins to pay some or all of the expenses for outpatient Prescription Drug Eligible Health Services.

Your Schedule of Benefits shows the outpatient Prescription Drug Deductible amounts that apply to Your plan. Once You have met Your outpatient Prescription Drug Deductible, We will start sharing the cost when You get outpatient Prescription Drug Eligible Health Services. You will continue to pay Copayments for Covered Benefits after You satisfy any applicable Deductible.

How Your Copayment/Coinsurance works

Your Copayment/Coinsurance is the amount You pay for each Prescription fill or refill in addition to Your outpatient Prescription Drug Deductible. Your Schedule of Benefits shows You which Copayments/Coinsurance You need to pay for specific Prescription fill or refill. You will pay any cost sharing directly to the Participating Pharmacy.

How Your outpatient Prescription Drug Maximum Out-of-Pocket Limit works

You will pay Your outpatient Prescription Drug Deductible and Copayments/Coinsurance up to the outpatient Prescription Drug Maximum Out-of-Pocket Limit for Your plan.

Your Schedule of Benefits shows the outpatient Prescription Drug Maximum Out-of-Pocket Limits that apply to Your plan. Once You reach Your outpatient Prescription Drug Maximum Out-of-Pocket Limit, Your plan will pay for outpatient Prescription Drug Covered Benefits for the remainder of that Calendar Year.

What Preauthorization requirements apply

For certain drugs, You, Your Prescriber or Your pharmacist needs to get approval from Us before We will cover the drug. This is called "Preauthorization" The requirement for getting approval in advance guides appropriate use of preauthorized drugs and makes sure they are Medically Necessary. For the most up-to-date information, call the toll-free number on Your member ID card or log on to Your secure member website at www.aetna.com.

There is another type of Preauthorization for Prescription Drugs, and that is Step Therapy. Step therapy is a type of Preauthorization where We require You to first try certain drugs to treat Your medical condition before We will cover another drug for that condition.

You will find the Step Therapy Prescription Drugs on the drug guide. For the most up-to-date information, call the toll-free Member Services number on Your member ID card or log on to Your secure member website at www.aetna.com.

How do I request a medical exception?

Sometimes You or Your Prescriber may seek a medical exception to get health care services for drugs not listed on the drug guide or for which health care services are denied through Preauthorization or Step Therapy. You, someone who represents You or Your Prescriber can contact Us and will need to provide Us with the required clinical documentation. Any exception granted is based upon an individual, case by case decision, and will not apply or to other members. If approved by Us, You will receive the Preferred or Non-Preferred Drug benefit level.

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

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

We will make a coverage determination within 24 hours after we receive Your request and will tell You, someone who represents You and Your **prescriber** of our decision.

Prescribing units

Some outpatient Prescription Drugs are subject to quantity limits. These quantity limits help Your Prescriber and pharmacist check that Your outpatient Prescription Drug is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by Us to set these quantity limits.

Some outpatient Prescription drugs are limited to 100 units dispensed per Prescription order or refill.

Any outpatient Prescription Drug that has duration of action extending beyond one (1) month shall require the number of Copayments per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) Copayments.

We reserve the right to include only one manufacturer's product on the **preferred drug guide** when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

We reserve the right to include only one dosage or form of a drug on the **preferred drug guide** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug guide** will be covered at the applicable **copayment** or **coinsurance**.

What Your plan doesn't cover – Exclusions and limitations

No coverage is available under this Certificate for the following:

General exceptions

Aviation.

We do not cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Convalescent and Custodial Care.

We do not cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

Conversion Therapy

We do not cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

Cosmetic Services.

We do not cover Cosmetic services, Prescription Drugs, or Surgery, unless otherwise specified, except that Cosmetic Surgery shall not include reconstructive Surgery when such service is incidental to or follows Surgery resulting from trauma, infection or diseases of the involved part, and reconstructive Surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. We also cover services in connection with reconstructive Surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic Surgery does not include Surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic Surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

Coverage Outside of the United States, Canada or Mexico.

We do not cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and Ambulance services to treat Your Emergency Condition.

Dental Services.

We do not cover dental services except for: care or treatment due to accidental Injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services sections of this Certificate.

Experimental or Investigational Treatment.

We do not cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, or when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

Felony Participation.

We do not cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

Foot Care.

We do not cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

Government Facility.

We do not cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

Jaw joint disorder

- Non-surgical treatment of Temporomandibular joint disorder (TMJ)

Medically Necessary.

In general, We will not cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise covered under the terms of this Certificate.

Medicare or Other Governmental Program.

We do not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, We will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

Military Service.

We do not cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance.

We do not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Services Not Listed.

We do not cover services that are not listed in this Certificate as being covered.

Services Provided by a Family Member

We do not cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Services Separately Billed by Hospital Employees

We do not cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services with No Charge

We do not cover services for which no charge is normally made.

Vision Services

We do not cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Vision Care section of this Certificate.

War

We do not cover an illness, treatment or medical condition due to war, declared or undeclared.

Workers' Compensation

We do not cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Outpatient prescription drugs

Limitations/Terms of Coverage

We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

Compounded Prescription Drugs will be Covered only when they contain at least one (1) ingredient that is a Covered legend Prescription Drug, and are obtained from a pharmacy that is approved for compounding.

Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Certificate. Your benefit for diabetic insulin, oral hypoglycemics, and diabetic Prescription Drugs, diabetic supplies, and equipment will be provided under this section of the Certificate if the Cost-Sharing is more favorable to You under this section of the Certificate than the Additional Benefits, Equipment and Devices section of this Certificate.

We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician’s office are Covered under the Outpatient and Professional Services section of this Certificate.

We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an “A” or “B” rating from USPSTF, or as otherwise provided in this Certificate. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Certificate.

A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

Who provides the care

Just as the starting point for coverage under Your plan is whether the services and supplies are Eligible Health Services, the foundation for getting covered care is the Network. This section tells You about Participating and Non-Participating Providers.

Participating Providers

We have contracted with Providers to provide Eligible Health Services to You. These Providers make up the Network for Your plan. For You to receive the Network level of benefits You must use Participating Providers for Eligible Health Services. There are some exceptions:

- Emergency services – refer to the description of Emergency Medical Services and Urgent Care in the *Eligible Health Services under Your plan* section.
- Pre-Hospital Emergency Medical Services and emergency Ambulance transportation.
- Urgent Care – refer to the description of Emergency Medical Services and Urgent Care in the *Eligible Health Services under Your plan* section.
- Transplants – see the description of transplant services in the *Eligible health services under your plan – specific conditions* section.
- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services.

You may select a Participating Provider from the Directory through your secure member website at <https://www.aetna.com/>. You can search Our online Directory, for names and locations of Providers.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve a Referral; an authorization to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

You will not have to submit claims for treatment received from Participating Providers. Your Participating Provider will take care of that for You. And We will directly pay the Participating Provider for what the plan owes.

Your PCP

We encourage You to access Eligible Health Services through a PCP. They will provide You with primary care.

A PCP can be any of the following Providers available under Your plan:

- General practitioner
- Family Physician
- Internist
- Pediatrician
- OB, GYN, and OB/GYN

How do You choose Your PCP?

You can choose a PCP from the list of PCPs in Our Directory. See the *Who provides the care, Participating providers* section.

Each covered family member is encouraged to select their own PCP. You may each select Your own PCP. You should select a PCP for Your covered Dependent if they are a minor or cannot choose a PCP on their own.

What will Your PCP do for You?

Your PCP will coordinate Your medical care or may provide treatment. They may send You to other Participating Providers.

Your PCP can also:

- Order lab tests and radiological services.
- Prescribe medicine or therapy.
- Arrange a Hospital Stay or a Stay in another facility.

In certain circumstances, You may designate a Specialist as Your PCP. See the *Medical Necessity, Referral and Preauthorization requirements* of this Certificate for more information about designating a Specialist.

How do I change my PCP?

You may change Your PCP at any time. You can call Us at the toll-free number on Your ID card or log on to Your secure member website at <https://www.aetna.com/> to make a change.

Non-Participating Providers

You also have access to Non-Participating Providers. This means You can receive Eligible Health Services from a Non-Participating Provider. If You use an Non-Participating Provider to receive Eligible Health Services, You are subject to a higher Out-of-Pocket expense and are responsible for:

- Paying Your Non-Participating Deductible
- Your Non-Participating Coinsurance
- Any charges over Our Recognized Charge
- Submitting Your own claims and getting Precertification

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 a Non-Participating Provider	When Your Provider stops participation with Aetna
Request for approval	You need to complete a transition 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 usually 90 days, but this may vary based on your condition. This date is based on the date the Provider terminated their participation with Us.

If you are pregnant and have entered your second trimester, the transitional period will include the time required for postpartum care directly related to the delivery.

We will authorize coverage for the transitional period only if the Provider agrees to our usual terms and conditions for contracting Providers.

What the plan pays and what You pay

Who pays for Your Eligible Health Services – this plan, both of Us, or just You? That depends. This section gives the general rule and explains these key terms:

- Your Deductible
- Your Copayments/Coinsurance
- Your Maximum Out-of-Pocket Limit

We also remind You that sometimes You will be responsible for paying the entire bill – for example, if You get care that is not an Eligible Health Service.

The general rule

When You get Eligible Health Services:

- You pay for the entire expense up to any Deductible limit.

And then

- The plan and You share the expense. The Schedule of Benefits lists how much Your plan pays and how much You pay for each type of health care service. Your share is called a Copayment/Coinsurance.

And then

- The plan pays the entire expense after You reach any Maximum Out-of-Pocket Limit.

When We say “expense” in this general rule, We mean the Recognized Charge for a Non-Participating Provider and Recognized Charge for an Non-Participating Provider. See the *Glossary* section for what these terms mean.

Important exception – when Your plan pays all

Under the Participating level of coverage, Your plan pays the entire expense for all Eligible Health Services under the preventive care and wellness benefit.

Important exceptions – when You pay all

You pay the entire expense for an Eligible Health Service:

- When You get a health care service or supply that is not Medically Necessary subject to the decision of an external appeal agent. See the *Medical Necessity, and Precertification requirements* section.
- Usually, when You get an Eligible Health Service from someone who is not an Aetna Provider. See the *Who provides the care* section.

In all these cases, the Provider may require You to pay the entire charge. And any amount You pay will not count towards Your Deductible or towards Your Maximum Out-of-Pocket Limit.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither You nor We are responsible for:

- Charges for which You have no legal obligation to pay
- Charges that would not be made if You did not have coverage
- Charges, expenses, or costs in excess of the Negotiated Charge

Where Your Schedule of Benefits fits in

How Your Deductible works

Your Deductible is the amount You need to pay, after paying Your coinsurance, for Eligible Health Services per Calendar Year as listed in the Schedule of Benefits. Your coinsurance does not count toward Your Deductible.

How Your Copayment/Coinsurance works

Your Copayment/Coinsurance is the amount You pay for Eligible Health Services after You have paid Your Deductible. Your Schedule of Benefits shows You which Copayments/Coinsurance You need to pay for specific Eligible Health Services.

You will pay the Physician, PCP Copayment/Coinsurance when You receive Eligible Health Services from any PCP.

How Your Maximum Out-of-Pocket Limit works

You will pay Your Deductible and Copayments/Coinsurance up to the Maximum Out-of-Pocket Limit for Your plan. Your Schedule of Benefits shows the Maximum Out-of-Pocket Limits that apply to Your plan. Once You reach Your Maximum Out-of-Pocket Limit, Your plan will pay for Covered Benefits for the remainder of that Calendar Year.

Important note:

See the Schedule of Benefits for any Deductibles, Copayments/Coinsurance, Maximum Out-of-Pocket Limit and maximum age, visits, days, hours, admissions that may apply.

Protection from Surprise Bills.

A surprise bill is a bill You receive in the following circumstances:

- For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
 - A participating Physician is unavailable at the time the health care services are performed;
 - A non-participating Physician performs services without Your knowledge; or
 - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the Referral is to a Non-Participating Provider and it may result in costs not covered by Us.

You will be held harmless for any non-participating Physician charges for the surprise bill that exceed Your in-network Copayment, Deductible or Coinsurance if You assign benefits to the non-participating Physician in writing. In such cases, the non-participating Physician may only bill You for Your in-network Copayment, Deductible or Coinsurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.aetna.com for a copy of the form. You need to mail a copy of the assignment of benefits form to Us at the address on Our website; Your ID card and to Your Provider.

Independent Dispute Resolution Process

Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity (IDRE) assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

When you disagree - Claim Determinations, Grievance and Appeals procedures

Claim Determinations

A. Claims

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling Member Services at the number on Your ID card or visiting Our website at www.aetna.com. Completed claim forms should be sent to the address on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address on Your ID card or visiting Our website at www.aetna.com.

C. Timeframe for Filing Claims

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations

Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or Experimental or Investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or Experimental or Investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-Service Claim Determinations

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

Grievance Procedures

A. Grievances

Our Grievance procedure applies to any issue not relating to a Medical Necessity or Experimental or Investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance

You can contact Us by phone at the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances: By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances: In writing, within 15 calendar days of receipt of Your Grievance.
(A request for a service or a treatment that has not yet been provided.)

Post-Service Grievances: In writing, within 30 calendar days of receipt of Your Grievance.
(A claim for a service or a treatment that has already been provided.)

All Other Grievances: In writing, within 30 calendar days of receipt of Your Grievance
(That are not in relation to a claim or request for a service or treatment.)

D. Grievance Appeals

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card , in person, or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances: The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances: 15 calendar days of receipt of Your Appeal.
(A request for a service or a treatment that has not yet been provided.)

Post-Service Grievances: 30 calendar days of receipt of Your Appeal.
(A claim for a service or a treatment that has already been provided.)

All Other Grievances: 30 business days of receipt of all necessary information to make a determination.
That are not in relation to a claim or request for a service or treatment.)

E. Assistance

If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

Utilization Review

We review health services to determine whether the services are or were Medically Necessary or Experimental or Investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically

Necessary. We have developed guidelines and protocols to assist Us in this process. For substance use disorder treatment, We will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for Your review upon request. For more information, call Member Services at the number on Your ID card or visit Our website at www.aetna.com.

Preauthorization Reviews

1. If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45 day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.
3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) or Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

Concurrent Reviews

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) or Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) or Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of the receipt of the requested information or 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of Urgent Care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) or Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) or Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) or Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) or Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) or Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient Hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.
4. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.
5. **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a Participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within 48 hours of the admission. After the first 14 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

Retrospective Reviews

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

Retrospective Review of Preauthorized Services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

Reconsideration

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider in writing.

Utilization Review Internal Appeals

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
 - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
 - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
 - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
 - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

Appeals

First Level Appeal

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.
2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.
3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Substance Use Appeal

If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

Second Level Appeal

If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external appeal. **The four (4) month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external Appeal.**

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and inform You, if necessary, of any additional information needed before a decision can be made.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.
2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.
3. **Expedited Appeal.** If Your Appeal relates to an urgent matter, We will decide the Appeal and provide written notice of the determination to You (or Your designee), and where appropriate, Your Provider, within 72 hours of receipt of the Appeal request.

Appeal Assistance

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

External Appeals

Your Right to an External Appeal

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service does not meet Our requirements for Medical Necessity (including appropriateness, health care setting, level of care or effectiveness of a Covered Benefit); or is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate; and
- In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
 - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
 - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

Your Right to Appeal a Determination that a Service is Not Medically Necessary

If We have denied coverage on the basis that the service does not meet Our requirements for Medical Necessity, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph above.

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If We have denied coverage on the basis that the service is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two requirements for an external appeal in paragraph above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; **or**
2. There does not exist a more beneficial standard service or procedure Covered by Us; **or**
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

Your Right to Appeal a Determination that a Service is Out-of-Network

If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two requirements for an external appeal in paragraph above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

Your Right to Appeal an Out-of-Network Referral Denial

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two requirements for an external appeal in paragraph above.

In addition, Your attending Physician must: certify that The Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

The External Appeal Process

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued Stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an Experimental or Investigational treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge You a fee of \$25 for each external appeal, not to exceed \$75 in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

Your Responsibilities

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

Coordination of benefits

This section applies when You also have group health coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **“Allowable expense”** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.
2. **“Plan”** is other group health coverage with which We will coordinate benefits. The term “plan” includes:
 - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
 - Medical benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.
 - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance coverage.
3. **“Primary plan”** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).
4. **“Secondary plan”** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.
2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
 - The plan of the parent who has custody will be primary;
 - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
 - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.

We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.

If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.

Except as described below, We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.
2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.
3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

If a blanket accident insurance policy issued in accordance with Section 1015.11 of the General Business Law contains a provision that its benefits are excess or always secondary, then this Certificate is primary.

When coverage ends - Termination

Termination

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group and/or Subscriber has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium had been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. For Children, until the end of the month in which the Child turns 26 years of age.
6. For all other Dependents, the day in which the Dependent ceases to be eligible.
7. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application, We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to one (1) year; Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.
9. The date that the Group Policy is terminated. If We terminate and/or decide to stop offering a particular class of group policies, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days' prior written notice.
10. If We elect to terminate or cease offering all hospital, surgical and medical expense coverage in the small group market in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.
11. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
12. The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

13. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage. See the Conversion Right to a New Contract after Termination section of this Certificate for Your right to conversion to an individual Policy.

When coverage may continue under the plan

Your coverage under this plan will continue if:

<p>Your employment ends because of illness, injury, sabbatical or other authorized leave as agreed to by the policyholder and us.</p>	<p>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:</p> <ul style="list-style-type: none"> Your coverage may continue, until stopped by the policyholder, but not beyond 36 months from the start of your absence.
<p>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.</p>	<p>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:</p> <ul style="list-style-type: none"> Your coverage will stop on the date that your employment ends.
<p>Your employment ends because:</p> <ul style="list-style-type: none"> Your job has been eliminated You have been placed on severance, or This plan allows former employees to continue their coverage. 	<p>You may be able to continue coverage. See the <i>Special coverage options after your plan coverage ends</i> section.</p>
<p>Your employment ends because of a paid or unpaid medical leave of absence</p>	<p>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:</p> <ul style="list-style-type: none"> Your coverage may continue until stopped by the policyholder but not beyond 36 months from the start of the absence.
<p>Your employment ends because of a leave of absence that is not a medical leave of absence</p>	<p>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:</p> <ul style="list-style-type: none"> Your coverage may continue until stopped by the policyholder but not beyond 36 months from the start of the absence.

<p>Your employment ends because of a military leave of absence.</p>	<p>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:</p> <ul style="list-style-type: none"> • Your coverage may continue until stopped by the policyholder but not beyond 36 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 We send you a notice of Your coverage ending?

We 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 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 the policyholder following the date on which you no longer meet the eligibility requirements.

Extension of Benefits, Continuation of Coverage and Conversion

Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Policy terminates, or on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the Injury or sickness that is the cause of the total disability.

A. When You May Continue Benefits

When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital Stay commencing, or Surgery performed, within 31 days from the date Your coverage ends. The Hospital Stay or Surgery must be for the treatment of the Injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to 12 months from the date Your coverage ends for Covered Services to treat the Injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

B. Termination of Extension of Benefits

Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment); or
- With respect to the 12-month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

C. Limits on Extended Benefits

We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Certificate ends; or
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

A. Qualifying Events

Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.
2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
 - Voluntary or involuntary termination of the Subscriber's employment;
 - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
 - Divorce or legal separation from the Subscriber; or
 - Death of the Subscriber.
3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
 - Voluntary or involuntary termination of the Subscriber's employment;
 - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
 - Loss of covered Child status under the plan rules; or
 - Death of the Subscriber.

If You want to continue coverage, You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date 36 months after the Subscriber's coverage would have terminated because of termination of employment;
2. If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Policy terminates. However, if the Group Policy is replaced with similar coverage, You have the right to become covered under the new Group Policy for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See the Conversion Right to a New Contract after Termination section of this Certificate.

B. Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than four (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

C. Availability of Age 29 Dependent Coverage Extension – Young Adult Option

The Subscriber's Child may be eligible to purchase continuation coverage under the Group's Policy through the age of 29 if he or she:

1. Is under the age of 30;
2. Is not married;
3. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
4. Lives, works or resides in New York State or Our Service Area; and
5. Is not covered by Medicare.

The Child may purchase continuation coverage even if he or she is not financially dependent on his or her parent(s) and does not need to live with his or her parent(s).

The Subscriber's Child may elect this coverage:

1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the Group or the Group's designee receives notice and We receive Premium payment; or
3. During an annual 30-day open enrollment period, in which case coverage will be prospective and will start within 30 days of when the Group or the Group's designee receives notice of election and We receive Premium payment.

The Subscriber or Subscriber's Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Certificate. The Child's children are not eligible for coverage under this option.

Conversion

Conversion Right to a New Contract after Termination

A. Circumstances Giving Rise to Right to Conversion

You have the right to convert to a new Policy if coverage under this Certificate terminates under the circumstances described below.

- 1. Termination of the Group Policy.** If the Group Policy between Us and the Group is terminated as set forth in the Termination of Coverage section of this Certificate, and the Group has not replaced the coverage with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Policy as direct payment members.
- 2. If You Are No Longer Covered in a Group.** If Your coverage terminates under the Termination of Coverage section of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Policy as a direct payment member.
- 3. On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Certificate because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Policy as direct payment members.
- 4. Termination of Your Marriage.** If a Spouse's coverage terminates under the Termination of Coverage section of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Policy as a direct payment member.
- 5. Termination of Coverage of a Child.** If a Child's coverage terminates under the Termination of Coverage section of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Policy as a direct payment member.
- 6. Termination of Your Temporary Continuation of Coverage.** If coverage terminates under the Termination of Coverage section of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Policy as a direct payment member.
- 7. Termination of Your Young Adult Coverage.** If a Child's young adult coverage terminates under the Termination of Coverage section of this Certificate, the Child is entitled to purchase a new Policy as a direct payment member.

B. When to Apply for the New Policy

If You are entitled to purchase a new Policy as described above, You must apply to Us for the new Policy within 60 days after termination of coverage under this Certificate. You must also pay the first Premium of the new Policy at the time You apply for coverage.

C. The New Policy

We will offer You an individual direct payment Policy at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. You may choose among any of the four Policies offered by Us. The coverage may not be the same as Your current coverage. If We determine that You do not reside in New York State, We may issue You or Your family members coverage on a form that We use for conversion in that state.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this Certificate

We prepared this 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. Also, you are bound by our interpretation of this Certificate when we administer your coverage, so long as we use reasonable discretion.

How we administer this plan

We apply policies and procedures we've develop 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 Participating 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. When an emergency or epidemic is declared, we may modify or waive **precertification**, **prescription** quantity limits or your cost share if you are affected. Only Aetna may waive a requirement of your plan. No other person – including the policyholder or Provider – can do this.

Changes in this Certificate

We may unilaterally change this Certificate upon renewal, if We give the Group 30 days' prior written notice.

Who May Change this Certificate

This Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer ("CEO") or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

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 Determinations, Grievance and Appeals 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.

Time to Sue

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within three (3) years from the date the claim was required to be filed.

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 before we learned of it.

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.

Some other money issues

Assignment

You cannot assign any benefits under this Certificate to any person, corporation or other organization. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill. See the How Your Coverage Works section of this Certificate for more information about surprise bills. Any assignment of benefits by You other than for monies due for a surprise bill will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

Financial sanctions exclusions

If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for Eligible Health Services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

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 Certificate if Premium payments are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Recovery of Overpayments

We sometimes pay too much for Eligible Health Services or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your Provider – to return what we paid. If we don't do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

Subrogation and Reimbursement

These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your Injury, Illness or other condition and We have provided benefits related to that Injury, Illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Certificate. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an Injury, Illness, or condition for which We provided benefits. Under Section 5-335 of the New York General Obligations Law, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury, Illness or condition sustained by You for which we have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your providers' claims and manage your plan. You can get a free copy of our Notice of Privacy Practices. Just call the toll-free number on your ID card.

When you accept coverage under this plan, you agree to let your Providers share information with us. We need information about your physical and mental condition and care.

Effect of benefits under other plans

Effect of a Health Maintenance Organization plan (an HMO plan) on coverage

If you are eligible and have chosen medical coverage under an HMO plan offered by the policyholder, you will be excluded from medical coverage (except vision care, if any,) on the date of your coverage under the HMO plan.

If you and your covered dependents:	Change of coverage:	Coverage takes effect:
Live in an HMO plan enrollment area	During an open enrollment period	Group policy anniversary date after the open enrollment period
Live in an HMO plan enrollment area	Not during an open enrollment period	Only if and when we give our written consent
Move from an HMO plan enrollment area or the HMO discontinues	Within 31 days	On the date you elect such coverage
Move from an HMO plan enrollment area or the HMO discontinues	After 31 days	Only if and when we give our written consent

Extension of benefits for pregnancy

If you are:	Evidence you must provide:	Extension:	Extension will end the earlier of:
In a hospital not affiliated with the HMO plan	The HMO plan provides an extension of benefits for pregnancy	Same length of time and for the same conditions as the HMO plan provides	<ul style="list-style-type: none"> The end of a 90 day period, or The date the person is not confined

No benefits will be paid for any charges for services rendered or supplies received under an HMO plan.

Effect of prior coverage - transferred business

Prior coverage means:

- Any plan of group coverage that has been replaced by coverage under part or this entire plan.
- The plan must have been sponsored by the policyholder (e.g., transferred business).
- If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

If your coverage under any part of this plan replaces any prior coverage, any benefits provided under such prior coverage may reduce benefits payable under this plan. See the *General coverage provisions* section of the schedule of benefits.

Health coverage under this plan will continue uninterrupted as to your dependent college student who takes a medically necessary leave of absence from school. See the *Special coverage options after your plan coverage ends – How can you extend coverage for a child in college on medical leave?* section.

Glossary A-M

Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

Ambulance

A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Appeal

A request for Us to review a Utilization Review decision or a Grievance again.

Behavioral Health Provider

An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for Mental Disorders and Substance Abuse under the laws of the jurisdiction where the individual practices.

Body Mass Index

This is a degree of obesity and is calculated by dividing Your weight in kilograms by Your height in meters squared.

Brand-Name Prescription Drug

A U.S. Food and Drug Administration (FDA) approved Prescription Drug marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Calendar Year

A period of 1 year beginning January 1st and ending on December 31st.

Certificate

This Certificate issued by Aetna Life Insurance Company, including the Schedule of Benefits and any attached riders.

Coinsurance

The specific percentage You and the plan have to pay for a health care service listed in the Schedule of Benefits.

Copay, Copayments

The specific dollar amount or percentage You have to pay for a health care service listed in the Schedule of Benefits.

Cosmetic

Services, drugs or supplies that are primarily intended to alter, improve or enhance Your appearance.

Covered Services or Covered Benefits

Eligible Health Services that meet the requirements for coverage under the terms of this plan, including:

1. They are Medically Necessary.
2. You received Precertification, if required.

Custodial Care

Services and supplies mainly intended to help meet Your activities of daily living or other personal needs. Care may be custodial care even if it prescribed by a Physician or given by trained medical personnel.

Deductible

The amount You pay for Eligible Health Services per Calendar Year before Your plan starts to pay as listed in the Schedule of Benefits.

Detoxification

The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This could be done by metabolic or other means determined by a Physician or a nurse practitioner working within the scope of their license. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a Facility, the Facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Directory

The list of Participating Providers for Your plan. The most up-to-date directory for Your plan appears at www.aetna.com under the provider search label. When searching provider search, You need to make sure that You are searching for Providers that participate in Your specific plan. Network Providers may only be considered for certain Aetna plans.

Durable Medical Equipment (DME)

Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an Illness or Injury
- Suited for use in the home
- Not normally used by people who do not have an Illness or Injury
- Not for altering air quality or temperature
- Not for exercise or training

Effective Date of Coverage

The date You and Your dependent's coverage begins under this Certificate as noted in Aetna's records.

Eligible Health Services

The health care services and supplies and Prescription Drugs listed in the *Eligible Health Services under Your plan* section and not carved out or limited in the *Exclusions* section or in the Schedule of Benefits.

Emergency Admission

An admission to a Hospital or treatment facility ordered by a Physician within 24 hours after You receive Emergency Medical Services.

Emergency Condition

A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Services

A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Experimental or Investigational

A drug, device, procedure, or treatment that We find is experimental or investigational because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the Illness or Injury involved
- The needed approval by the FDA has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services
- Written protocols or a written consent form used by a facility Provider state that it is experimental or investigational.

External Appeal Agent

An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Formulary Exclusions List

A list of Prescription Drugs not covered under the plan. This list is subject to change.

Generic Prescription Drug

A Prescription Drug with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Grievance

A complaint that You communicate to Us that does not involve a utilization review determination.

Group Policy

The Group Policy consists of several documents taken together. These documents are:

- The group application
- The Group Policy
- The Certificate
- The Schedule of Benefits
- Any amendments to the Group Policy, Certificate, and Schedule of Benefits

Health Professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, Physicians, nurses, and physical therapists.

Home Health Care Agency

An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home Health Care Plan

A plan of services prescribed by a Physician or other health care practitioner to be provided in the home setting. These services are usually provided after Your discharge from a Hospital or if You are homebound.

Hospice Care

Care designed to give supportive care to people in the final phase of a Terminal Illness and focus on comfort and quality of life, rather than cure.

Hospice Care Agency

An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide Hospice Care. These services may be available in Your home or inpatient setting.

Hospice Care Program

A program prescribed by a Physician or other Health Professional to provide Hospice Care and supportive care to their families.

Hospice Facility

An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide Hospice Care.

Hospital

A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major Surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);

- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Illness

Poor health resulting from disease of the body or mind.

Infertile/Infertility

A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

Injury

Physical damage done to a person or part of their body.

Institutes of Excellence™ (IOE) Facility

A facility designated by Aetna in the Provider Directory as Institutes of Excellence Network Provider for specific services or procedures.

Intensive Outpatient Program (IOP)

Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of 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.

Jaw Joint Disorder

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint,
- A Myofascial Pain Dysfunction (MPD) of the jaw, or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Mail Order Pharmacy

A pharmacy where Prescription Drugs are legally dispensed by mail or other carrier.

Maximum Out-of-Pocket Limit

The maximum out-of-pocket amount for payment of Copayments and coinsurance including any Deductible, to be paid by You or any covered dependents per Calendar Year for Eligible Health Services.

Medically Necessary/Medical Necessity

Health care services that We determine a Provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that We determine are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease
- Not primarily for the convenience of the patient, Physician, or other health care Provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Following the standards set forth in our clinical policies and applying clinical judgement.

Mental Disorder

A Mental Disorder as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental Disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

Morbid Obesity/Morbidly Obese

This means the Body Mass Index is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes

Negotiated Charge

For health coverage, this is either:

- The amount a Participating Provider has agreed to accept
- The amount we agree to pay directly to a Participating Provider or third party vendor (including any administrative fee in the amount paid)

for providing services, Prescription Drugs or supplies to plan members. This does not include Prescription Drug services from a network pharmacy.

For Prescription Drug services from a Participating Pharmacy:

The amount We established for each Prescription Drug obtained from a Participating Pharmacy under this plan. This Negotiated Charge may reflect amounts We agreed to pay directly to the Participating Pharmacy or to a third party vendor for the Prescription Drug, and may include a rebate, an additional service or risk charge set by Us. Any rebates received by Us may be applied to the Negotiated Charge. Rebates may not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may change the Negotiated Charge under this plan.

Non-Participating Drug

A Prescription Drug or device that may have a higher out-of-pocket cost than a preferred drug.

Non-Participating Provider

A Provider who is not a Participating Provider or National Advantage Program (NAP) Provider and does not appear in the Directory for Your plan.

Non-Participating Pharmacy

A pharmacy that is not a Participating Pharmacy, and does not appear in the Directory for Your plan.

Non-preferred drug

A Prescription Drug or device that may have a higher out-of-pocket cost than a Preferred Drug.

Out-of-network provider

A **provider** who is not a **network provider**.

Partial Hospitalization Treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat Mental Disorders and Substance Abuse. The treatment plan must meet these tests:

- It is carried out in a Hospital, Psychiatric Hospital or Residential Treatment Facility on less than a full-time inpatient basis.
- It is in accordance with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a Psychiatrist who weekly reviews and evaluates its effect.

Participating Provider

A Provider listed in the Directory for Your plan. However, a NAP Provider listed in the NAP directory is not a Participating Provider.

Participating Pharmacy

A Retail Pharmacy, Mail Order Pharmacy or Specialty Pharmacy that has contracted with Aetna, an affiliate, or a third party vendor, to provide outpatient Prescription Drugs to You.

Pharmacy

An establishment where Prescription Drugs are legally dispensed. This includes a Retail, Mail Order and Specialty Pharmacy.

Physician

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

Preauthorization, Preauthorize

A requirement that You or Your Physician contact Aetna before You receive coverage for certain services. This may include a determination by Us as to whether the service is Medically Necessary and eligible for coverage.

Preferred Drug

A Prescription Drug or device that is listed on the Preferred Drug guide.

Preferred Drug Guide

A list of Prescription Drugs and devices established by Aetna or an affiliate. It does not include all Prescription Drugs and devices. This list can be reviewed and changed by Aetna or an affiliate. A copy of the Preferred Drug guide is available at Your request. Or You can find it on the Aetna website at www.aetna.com/formulary.

Preferred Network Pharmacy

A Network Retail Pharmacy that Aetna, has identified as a Participating Pharmacy.

Preferred Provider

A Provider who has a contract with Us to provide services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see a Preferred Provider.

Premium

The amount You or the policyholder are required to pay to Aetna to continue coverage.

Prescriber

Any Provider acting within the scope of their license, who has the legal authority to write an order for outpatient Prescription Drugs.

Prescription

As to hearing care:

A written order for the dispensing of Prescription electronic hearing aids by otolaryngologist, otologist or audiologist.

As to Prescription Drugs:

A written order for the dispensing of a Prescription Drug by a Prescriber. If it is a verbal order, it must promptly be put in writing by the Participating Pharmacy.

As to vision care:

A written order for the dispensing of Prescription lenses or Prescription contact lenses by an ophthalmologist or optometrist.

Prescription Drug

A Drug, biological, or compounded Prescription which, by State and Federal Law, may be dispensed only by Prescription or administered by a person who is acting within his or her capacity as a paid Health Professional.

Primary care Physician (PCP)

A Physician who:

- The Directory lists as a PCP
- Is selected by a person from the list of PCPs in the Directory
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care Physician, an internist, a pediatrician, OB, GYN or OB/GYN
- Is shown on Aetna's records as Your PCP

Provider(s)

A Physician, other Health Professional, Hospital, Skilled Nursing Facility, Home Health Care Agency or other entity or person licensed or certified under applicable state and federal law to provide health care services to You. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric Hospital

An institution specifically licensed or certified as a Psychiatric Hospital by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, Drug abuse, Mental Disorders, or mental illnesses.

Psychiatrist

A Psychiatrist generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

Recognized Charge

The amount of an **out-of-network/non-participating provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	Recognized charge
Professional services and other services or supplies not mentioned below	300% of the Medicare allowed rate
Services of hospitals and other facilities	300% of the Medicare allowed rate
Prescription drugs	110% of the average wholesale price (AWP)
Dental expenses	
Important note: If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.	

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
 - The method CMS uses to set Medicare rates
 - What other **providers** charge or accept as payment
 - How much work it takes to perform a service
 - Other things as needed to decide what rate is reasonable for a particular service or supply

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For **DME**, our rate is 75% of the rates CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate is 100% of the rates CMS establishes for those medications.

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services

Get the most value out of your benefits

We have online tools to help decide whether to get care and if so, where. Use the "Estimate the Cost of Care" tool on **Aetna's** secure member website. **Aetna's** secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to **Aetna's** secure member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

R.N.

A registered nurse.

Residential Treatment Facility (Mental Disorders)

Coverage for residential treatment services is limited to facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the Public Health Law; and, in other states, to facilities that are licensed or certified to provide the same level of treatment.

Residential Treatment Facility (Substance Abuse)

Coverage for residential treatment services is limited to OASAS-certified facilities defined in 14 NYCRR 819.2(a)(1) and to services provided in such Facilities in accordance with 14 NYCRR Parts 817 and 819; and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

Retail Pharmacy

A community pharmacy that dispenses outpatient Prescription Drugs at retail prices.

Room and Board

A facility's charge for Your overnight Stay and other services and supplies expressed as a daily or weekly rate.

Schedule of Benefits

The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, Referral requirements, and other limits on Covered Services.

Semi-Private Room Rate

An institution's Room and Board charge for most beds in rooms with 2 or more beds. If there are no such rooms, Aetna will calculate the rate based on the rate most commonly charged by similar institutions in the same Geographic Area.

Service Area

The Geographic Area where Participating Providers for this plan are located.

Skilled Nursing Facility

A facility specifically licensed as a Skilled Nursing Facility by applicable state and federal laws to provide skilled nursing care.

Skilled Nursing Facilities also include rehabilitation Hospitals, and portions of a rehabilitation Hospital and a Hospital designated for skilled or rehabilitation services.

Skilled Nursing Facility does not include institutions that provide only:

- Minimal care
- Custodial Care services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of Mental Disorders or Substance Abuse.

Skilled Nursing Services

Services provided by an R.N. or L.P.N. within the scope of their license.

Specialist

A Physician who practices in any generally accepted medical or surgical sub-specialty.

Specialty Prescription Drugs

These are Prescription Drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these Specialty Prescription Drugs by calling the toll-free number on Your ID card or by logging on to Your secure member website at www.aetna.com.

Specialty Pharmacy

This is a designated by Aetna as a **network pharmacy** to fill Prescriptions for **Specialty** Prescription Drugs.

Stay

A full-time inpatient confinement for which a Room and Board charge is made.

Step Therapy

A form of Preauthorization under which certain Prescription Drugs will be excluded from coverage, unless a first-line therapy Drug(s) is used first by You. The list of step-therapy Drugs is subject to change by Aetna or an affiliate. An updated copy of the list of Drugs subject to Step Therapy shall be available upon request by You or may be accessed on the Aetna website at www.aetna.com/formulary.

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions You cannot attribute to a Mental Disorder that are a focus of attention or treatment, or an addiction to nicotine products, food or caffeine intoxication.

Surgery Center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient Surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare)

Surgery or Surgical Procedures

The diagnosis and treatment of Injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Telemedicine

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service.

Services can be provided by:

- Two-way audiovisual teleconferencing;
- Telephone calls , except for behavioral health services
- Any other method required by state law

Terminal illness

A medical prognosis that You are not likely to live more than 12 months.

Therapeutic Drug Class

A group of Drugs or medications that have a similar or identical mode of action. Or are used for the treatment of the same or similar disease or Injury.

Urgent Care

Medical care for an Illness, Injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center

A licensed facility (other than a Hospital) that provides Urgent Care.

Us, We, Our

Aetna Life Insurance Company and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Walk-In Clinic

A freestanding health care facility. Neither of the following should be considered a Walk-In Clinic:

- An emergency room
- The outpatient department of a Hospital.

You, Your

The member.

Wellness programs

Wellness Benefits

Exercise Facility Reimbursement

We will partially reimburse the Subscriber and the Subscriber's covered Spouse for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities which maintain equipment and programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).

In order to be eligible for reimbursement, you must:

- Be an active member of the exercise facility or attend classes at the exercise facility, and
- Complete 50 visits in a six (6)-month period.

In order to obtain reimbursement, at the end of the six (6)-month period, you must submit:

- A completed reimbursement form; Documentation of the visits from the facility.
- A copy of your current facility bill which shows the fee paid for your membership; classes.

Once we receive the completed reimbursement form; documentation of the visits and the bill, you will be reimbursed the lesser of \$200 for the Subscriber and \$100 for the Subscriber's covered Spouse or the actual cost of the membership per six (6)-month period. Reimbursement will be issued only after you have completed each six (6)-month period even if 50 visits are completed sooner.

Aetna Life Insurance Company

Amendment

Amendment effective date: January 1, 2022

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

The following replaces the Discount Programs provision of your Certificate.

Discount programs

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third party service Providers". These third party service Providers may pay us so that they can offer you their services.

Third party service Providers are independent contractors. The third party service Provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service Providers for the services they offer. You are responsible for paying for the discounted goods or services.

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 1
Issue Date February 28, 2022

Aetna Life Insurance Company

Hartford, Connecticut 06156

CERTIFICATE RIDER

Policyholder: Pace University
Group Policy No GP-0181579
Effective Date: January 1, 2022

The following summarizes changes made in your Certificate of Insurance. This Rider is effective on the date shown above.

Wellness Benefits

Wellness Program

1. Purpose.

The purpose of this wellness program is to encourage you to take a more active role in managing your health and well-being.

2. Description.

We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities:

- A health risk assessment tool
- A designated smoking cessation program
- A designated weight management program
- A designated stress management program
- A designated health or fitness incentive program
- Designated online wellness activities
- Designated healthy activities
- Self-management of chronic diseases
- Other programs we determine have a nexus to health

3. Eligibility.

You and your covered Spouse can participate in the wellness program.

4. Participation.

The preferred method for accessing the wellness program is through our website at www.aetna.com. You need to have access to a computer with internet access in order to participate in the website program. However, if you do not have access to a computer, please call us at the number on Your ID card and we will provide you with information regarding how to participate without internet access.

5. Rewards.

Rewards for participation in a wellness program include:

- Full or partial reimbursement of the cost of participating in smoking cessation or weight management programs.
- Monetary rewards in the form of cash, gift cards or gift certificates, so long as the recipient is encouraged to use the reward for a product or service that promotes good health, such as healthy cook books, over-the-counter vitamins or exercise equipment.



Dan Finke

President

Aetna Life Insurance Company
(A Stock Company)

Additional Information Provided by

Pace University

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:

Pace University Health Plan

Employer Identification Number:

13-5562314

Plan Number:

510

Type of Plan:

Welfare

Type of Administration:

Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

Pace University
100 Summit Lake Drive
Valhalla, NY 10599
Telephone Number: (914) 923-2714

Agent For Service of Legal Process:

Pace University
100 Summit Lake Drive
Valhalla, NY 10599

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:

December 31

Source of Contributions:

Employer and Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by Vice President.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- (1) all stages of reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/home/regsguidance.asp>, and this U.S. Department of Labor website, <https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans>.

Important disclosure information about New York large group plans

THE HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

allows the designation of a primary care provider, you have the right to participate in our network and who is available to accept you or your insurance coverage designates a primary care provider automatically, Aetna designates one for you. For information on how to select a primary care provider, contact your Employer or, if you are a current member on the back of your ID card.

For the designation of a primary care provider for a child, you may designate a provider.

For obstetric or gynecological care and requires the designation of a provider. You may need prior authorization from Aetna or from any other person (including your Employer) to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may require certain procedures, including obtaining prior authorization for certain services, such as cesarean section, or procedures for making referrals. For a list of participating health care professionals in obstetrics or gynecology, contact your Employer or, if you are a current member on the back of your ID card.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and Aetna Health Insurance Company of New York and affiliates (Aetna).

Table of contents

- We offer quality health plans**
- Features of a large group plan**.....
 - Avoid unexpected bills
 - Get a free printed directory.....
 - No coverage based on U.S. trade sanctions
 - Coverage for transplants and other complex conditions
 - Clinical policy bulletins
- Member rights and responsibilities**
- Nondiscrimination policy for genetic testing.....
- Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)
- Women’s Health and Cancer Rights Act of 1998 (WHCRA).....
- Your right to enroll later
- When you have a new dependent.....
- Important information for New York plans**
- Using your NY plan
- Precertification: getting approvals for services
- We check if it’s medically necessary.....
- Our plans comply with mental health laws.....
- What to do if you disagree with us.....
- Grievances
- External appeal.....

Your rights to enroll later if you decide not to enroll now.....

More information is available upon request.....

New York State Out-of-Network Emergency and Surprise Medical Bill

Assignment of Benefits form

Out-of-network reimbursement examples for large group coverage.....

.28.354.1-NY (6/20)

Here is important disclosure information about our plans. It's followed by required New York content. If there is any difference between this disclosure and your plan documents, the plan documents govern.

We offer quality health plans

By following health plan accreditation standards of the National Committee for Quality Assurance (NCQA), we offer you quality health plans. Visit [Aetna.com/ individuals-families-health-insurance/document-library/documents/2019Disclosures/NCQA-MED-Disclosures-FI-SI.pdf](https://www.aetna.com/individuals-families-health-insurance/document-library/documents/2019Disclosures/NCQA-MED-Disclosures-FI-SI.pdf) to learn more about how we meet the NCQA accreditation and standards. You can also call us at the number on your member ID card to ask for a printed copy.

This document details how to:

Understand your health plan

- Benefits and services included in, and excluded from, your coverage
- Prescription drug benefit
- Mental health and addiction benefits
- Care after office hours, urgent care, and emergency care

Get plan information online and by phone

- How you can reach us
- Help for those who speak another language and for the hearing impaired
- Get information about how to file a claim
- Search our network for doctors, hospitals and other health care providers
- Accountable care organizations (ACOs)
- Our quality management programs, including goals and outcomes

Know the costs and rules for using your plan

- What you pay
- Your costs when you go outside the network
- Precertification: getting approvals for services
- We study the latest medical technology
- How we make coverage decisions
- Complaints, appeals and external reviews

Understand your rights and responsibilities

- Member rights and responsibilities
- Notice of Privacy Practices

Features of a large group plan

If you're a member, not all of the information in this document applies to your specific plan. Most information applies to all plans, but some does not. For example, not all plans have prescription drug or behavioral health benefits. There's also information that may only apply to a handful of states and plans. To be sure about which plan features apply to you, check your Summary of Benefits and Coverage plan documents. Can't find them? Ask your benefits administrator or call Member Services to have a copy of your plan documents mailed to you.

Avoid unexpected bills

To avoid a surprise bill, make sure you check your plan documents to see what's covered before you get health care. Also, make sure you get care from a provider who is part of your plan's network. This just makes sense because:

- We have negotiated lower rates for you
- Network doctors and hospitals won't bill you above our negotiated rates for covered services
- You have access to quality care from our provider network

To find a network provider, sign in to **Aetna.com** and select "Find Care" from the top menu bar to start your search. To learn more about how we pay out-of-network benefits when a plan allows them, visit **Aetna.com** and type "how Aetna pays" into the search box.

Get a free printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your member ID card.

No coverage based on U.S. trade sanctions

If U.S. trade sanctions consider you a "blocked person," the plan can't provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan, in most cases, can't provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we can't pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan can't pay for those services. For more information, visit **Treasury.gov/resource-center/sanctions/pages/default.aspx** to read about U.S. trade sanctions.

Coverage for transplants and other complex conditions

Our National Medical Excellence Program® (NME) is for members who need a transplant or have a condition that can only be treated at a certain hospital. You may need to visit an Aetna Institutes of Excellence™ hospital to get coverage for the treatment. Some plans won't cover the service if you don't. We choose hospitals for the NME program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

Clinical policy bulletins

We write a report about a product or service when we decide if it's medically necessary. We call the report a clinical policy bulletin (CPB). CPBs guide us in deciding whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents. CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can visit **Aetna.com/health-care-professionals/clinical-policy-bulletins.html** to read CPBs. No internet? Call the number on your Aetna member ID card and ask for a copy of a CPB for any product or service.

Member rights and responsibilities

We don't consider race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Federal law requires network providers to do the same.

Nondiscrimination policy for genetic testing

We don't use the results of genetic testing to discriminate, in any way, against applicants or enrollees. Also, you choose if you want to tell us your race or ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care and to serve you better.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

If you're a participant in an employer-funded group health plan, you're entitled to certain rights and protections under ERISA. Some of those rights are listed below. Your rights are outlined in more detail in your plan documents. Below are some of your rights.

- Receive, free of charge, information about your plan and benefits.
- Upon written request to your plan administrator, examine copies of documents governing the operation of the plan, contracts, collective bargaining agreements, annual reports and more. The administrator may charge you a reasonable copy fee.
- Receive a copy of procedures used to determine a qualified domestic relation or medical child support order.
- Continue group health coverage for you, your spouse or dependents if there is a loss of coverage as the result of a qualifying event.
- Know why a claim was denied.
- Exercise your rights and take steps to enforce your rights, without discrimination or retribution.
- Get answers to your questions about the plan. Contact your plan administrator with questions about your plan. If they don't provide the information you asked for, you can get help from the nearest office of the Employee Benefits Security Administration, which is part of the U.S. Department of Labor. Look them up online or in your local telephone directory.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Benefits will be provided to a person who has already undergone a mastectomy as a result of breast cancer while covered under a different health plan. Coverage is provided according to your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents.

For more information:

- Call the number on your member ID card
- Visit the U.S. Department of Labor at [DOL.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf](https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf)

Your right to enroll later

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops contributing to the other coverage).

When you have a new dependent

Getting married? Having a baby? If you chose not to enroll during the normal open enrollment period, you may enroll within 31 days after a life event. Examples of life



events are marriage, divorce, birth, adoption, and placement for adoption. Talk to your benefits administrator for more information or to request special enrollment.

Important information for New York plans

Type of insurance coverage

Aetna's large group plans are considered commercial insurance plans under New York Law. Our large group plans offer comprehensive health insurance coverage. Check your selected plan of benefits to see if you have out of network benefits.

Using your NY plan

You can choose any primary care provider (PCP) who participates in the Aetna network and who is accepting new patients.

A PCP may be a general practitioner, family physician, internist or a pediatrician. Each covered family member may select his or her own PCP. Your PCP provides routine preventive care and will treat you for illness or injury. Your PCP may refer you to other network doctors and hospitals for covered services and supplies. The PCP can also order lab tests and X-rays, prescribe medicines or therapies and arrange hospitalization. The online provider directory indicates whether a provider is accepting new patients. You can also ask the provider's office to confirm when scheduling an appointment.

Tell us who you chose to be your PCP

Each member of the family may choose a different PCP from the Aetna network. Enter the ID number of the PCP you choose on your enrollment form.

You can change your PCP or specialist at any time. Log in at **Aetna.com** or call the Member Services toll-free number on your Aetna ID card. The change will become effective when we receive and approve the request.

Making your specialist your PCP

If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition, who will be responsible for and capable of providing and coordinating your primary and specialty care. This referral will be issued based on a treatment plan that is approved by Aetna, in consultation with the primary care provider if appropriate, the specialist, and you or your authorized representative.

Please call Member Services at the toll-free number in your ID card or call **1-888-982-3862** to request these services.

Direct Access Ob/Gyn program

This program allows female members direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such examinations, and treatment of acute gynecologic conditions, including care for pregnancy-related services, from a qualified participating provider of the member's choice.

Direct specialist care for life threatening conditions If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request access to a specialty care center or to a specialist responsible for providing or coordinating your medical care. To request these services, please call Member Services at the toll-free number on your ID card or call **1-888-982-3862**.

Referrals: Your PCP will refer you to a specialist when needed

You never need to get a referral if you have an Aetna Open Access® Managed Choice, Aetna Open Access® Elect Choice or Open Choice® plan. With the Managed Choice plan, you will receive the highest level of benefits under the plan when you get a referral from your PCP before you see a network specialist.

A referral is a written request for you to see another doctor. Some doctors can send the referral right to your specialist for you. There's no paper involved. Talk to your doctor to understand why you need to see a specialist. And remember to always get the referral before you receive the care.

Getting a referral from your PCP is not the same as getting approval (called precertification) from the plan. Some health care services require both. For more information, read the "Precertification: getting approvals for services" section of this booklet.

Remember these points about referrals:

- You do not need a referral for emergency care or urgent care.
- If you do not get a referral when required, the plan will pay for the service as an out-of-network benefit, if available.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an ob/gyn without a referral. See "Direct Access Ob/Gyn program."
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.
- Certain services, such as inpatient stays, outpatient surgery and certain other medical procedures and tests, require both a PCP referral and precertification. See the "Precertification: getting approvals for services" section for details.

Referrals within physician groups

Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask us for a coverage exception to go outside this group. You may also need to precertify these services. And you may need permission from the physician group as well.

Out-of-network referrals

If a covered service you need isn't available from a network provider or facility with the training or expertise needed for your condition, or if a participating provider is not geographically accessible, your PCP may refer you to an out-of-network provider. Your PCP or other network provider must get preapproval from Aetna and issue a special nonparticipating referral for services from out-of-network providers to be covered.

Standing referrals

If you have a condition that requires ongoing care from a specialist, you may request a standing referral from your PCP or Aetna to such a specialist.

You don't need a PCP referral for:

- Emergency care — see the "Emergency care" section to learn more
- Urgent care — see the "Emergency care" section to learn more
- Direct access services — certain routine and preventive services do not require a referral under the plan when accessed in accordance with the age and frequency limitations outlined in the "What the Plan Covers" and the "Summary of Benefits" sections of your plan documents. You can directly access these network specialists for:
 - Routine gynecologist visits
 - Routine eye exams in accordance with the schedule
 - An annual screening mammogram for age-eligible women
 - Routine prenatal care (precertification may be required)

Precertification: getting approvals for services Sometimes we will pay for care only if we have given an approval before you get it. We call that precertification or preauthorization. We usually only need to pre-certify more serious care like surgery or being admitted to a hospital. Your PCP or Aetna network doctor will get this approval for you. If the request is to go outside the network, you may have to get this approval yourself. To do so, call the precertification number on your Aetna ID card, **1-877-204-9186**, or send your request to:

Aetna
1425 Union Meeting Road Blue Bell,
PA 19422

You must get the precertification before you receive the care. Your plan documents list all the services that require you to get precertification. If you don't have a service pre-certified when required, you may incur a penalty. Please see your plan documents for more information.

Prospective reviews

We'll notify your doctor within three business days. If we have all the information necessary to review the request, we will make our decision and notify you (or your designee) and your doctor, by telephone and in writing, within three business days of receipt of the necessary information.

If we need more information, we will request it within three calendar days. You or your doctor will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make our decision and notify you (or your designee) and your doctor, by telephone and in writing, within three business days of our receipt of the information. If we do not receive all necessary information within 45 days, we will make our decision within 15 calendar days of the end of the 45-day period.

Time frames for urgent care requests

If we have all information necessary to make a decision, we will do so and notify you (or your designee) and your doctor, by telephone and in writing, within 72 hours of receipt of the request. If we need more information, we will ask for it within 24 hours. You or your doctor will then have 48 hours to submit the information. We will make our decision and notify you and your doctor, by telephone and in writing, within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

Time frames for home care services

After receiving a request for coverage of home care services following an inpatient hospital admission, we will make our decision and notify you (or your designee) and your provider, by telephone and in writing, within one business day of our receipt of the necessary information. If the day after the request falls on a weekend or holiday, we'll notify you within 72 hours of receipt of the necessary information. We will not deny coverage for home care services while our decision is pending.

Time frames for rehabilitation service requests, following an inpatient hospital stay

Starting January 1, 2021, we'll make a decision upon receipt of all necessary information within one business day. We'll notify you (or your designee) and your doctor of the decision.

Time frame for inpatient substance use disorder treatment

If we receive a request for coverage of inpatient substance use disorder treatment at least 24 hours prior to discharge from an inpatient hospital admission, we will make our decision and notify you (or your designee) and your provider, by telephone and in writing, within 24 hours of our receipt of the necessary information. We will not deny coverage for the treatment while our decision is pending.

What we look for when reviewing a precertification request

First, we check to see that you are still a member. And we make sure the service is a covered expense under your plan. We also check that the service and place requested to perform the service is cost effective. If we know of a treatment or place of service that is just as effective but costs less, we may talk to your doctor about it. We also look to see if you qualify for one of our care management programs. If so, one of our nurses may call to tell you about it and help you understand your upcoming procedure.

We follow up on services we precertify

There are other steps to our utilization review process. These include:

Concurrent review: We begin this process if your hospital stay lasts longer than what was approved for coverage. We make sure it is necessary for you to be in the hospital. We look at the level and quality of care you are getting. We will notify you or your doctor of our decision of whether to continue covering your hospital stay. Utilization review decisions for services during the course of care (concurrent reviews) will be made and notice provided to you (or your designee) or your provider, by telephone and in writing, within one business day of receipt of all necessary information. If we need additional information, we will request it within 24 hours. You or your provider will then have at least 48 hours to submit the information. We will make a determination and provide notice to you (or your designee) or your provider, by telephone and in writing, within the earlier of: (a) one business day of the receipt of necessary information, or (b) the end of the time period allotted to provide the clinical information.

Discharge planning: We begin planning your discharge. This process can begin at any time. We look to see if you may benefit from any of our programs. We might have a nurse case manager follow your progress. Or we might recommend that you try a wellness program after you're home.

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits for the member after they are released from the inpatient facility.

Retrospective review: We review the claim for services after you are discharged. We may look over your medical records and claims from your doctors and the hospital. We look to see that you received appropriate care and if there was any waste or unnecessary costs. We may deny coverage if the information presented is materially different from what was originally presented during the precertification process. If we deny coverage, we will tell you and your doctor within 30 days.

If we need additional information, we will request it within 30 calendar days. You or your doctor will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and your provider in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day period. If we have all the necessary information and fail to make a determination within the applicable time frames, you may consider this a denial and file an appeal.

To contact the utilization review agent, call the precertification number on your Aetna ID card or **1-877-204-9186** weekdays from 8 AM to 5 PM ET. After hours, you can leave a message. If your doctor has a question about your coverage, your doctor or you may write to or call our Patient Management department at the address or phone number on your Aetna ID card.

Your doctor can ask us to reconsider a denial if we did not attempt to communicate with them first. For precertification and concurrent reviews, your doctor can request a reconsideration review. We will reconsider the denial within one business day. If we uphold the denial, we will notify you and your doctor in writing with appeal instructions. See "What to do if you disagree with us" to learn more.

We may deny coverage for a previously precertified treatment, service or procedure if:

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the precertification request.
- The relevant medical information presented to us upon retrospective review existed at the time of precertification but was withheld or not made available to us.
- We were not aware of the existence of such information at the time of the precertification review.
- Had we been aware of such information, the treatment, service or procedure being requested would not have been approved. The determination is made using the same specific standards, criteria or procedures as used during the precertification review.

Member payment estimator tool for New York members

If a service or procedure is not listed in the member payment estimator tool on your member website, you can obtain an estimated cost by completing the appropriate Member Request for Estimate form on our website.



Please visit the state information section at [Aetna.com/ individuals-families/member-rights-resources/ rights/state-specific-information.html](https://www.aetna.com/individuals-families/member-rights-resources/rights/state-specific-information.html) for the form or to link to an online price estimator tool.

An “out of network” doctor is one with whom we do not have a contract for discounted rates. We don’t know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor’s bill. Most of the time, you will pay more money out of your own pocket if you choose to see an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan recognizes, or allows. Your doctor may bill you for the dollar amount the plan doesn’t recognize. You’ll also pay higher copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or out-of-pocket limits.

This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure.

When you choose to see an out-of-network doctor, we pay for your health care depending on the plan you or your employer chooses. Some of our plans pay for out-of-network services by looking at what Medicare would pay and adjusting that amount up or down. Our plans range from paying 90 percent of Medicare (that is, 10 percent less than Medicare would pay) to 300 percent of Medicare (the Medicare rate multiplied by three). Some plans pay for out-of-network services based on what is called the usual and customary charge or reasonable amount rate. These plans use information from FAIR Health, Inc. (**Fairhealth.org**), which is a not-for-profit company that reports how much providers charge for services in any ZIP code.

When you choose to enroll in a plan with out-of-network coverage, you should consider how plans based on Medicare rates compare to plans based on “usual and customary” charges. Roughly speaking, in New York for all services combined, 300 percent of Medicare rates are the same as the usual and customary charges.

You can call Member Services at the toll-free number on your Aetna ID card to find out the method your plan uses to reimburse out-of-network doctors. You can also ask for an estimate of your share of the cost for out-of-network services you are planning. The way of paying out-of-network doctors and hospitals applies when you choose to get care out of network.

Emergency care

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is defined as a medical or behavioral condition that produces symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy
- Serious impairment of the person’s bodily functions
- Serious dysfunction of any bodily organ or part of the person
- Serious disfigurement of the person

Treatment for an emergency medical condition is not subject to prior approval. However, whether you are in or out of an Aetna service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

Call the local emergency hotline (ex. **911**) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your PCP. Notify your PCP as soon as possible after receiving treatment.

If you are admitted to an inpatient facility, you or a family member or friend acting on your behalf should notify your PCP or Aetna as soon as possible.

Covered expenses for emergency medical conditions are payable in accordance with your plan. Please refer to your summary of benefits for the applicable copay, deductible and coinsurance amounts that apply.

Urgent care

Care for certain conditions (such as severe vomiting, earaches, sore throats or fever) is considered "urgent care." You can get urgent care from your PCP or an urgent care facility. If you're traveling outside your Aetna service area or if you are a student who is away at school, you are covered for any urgently needed care rendered by any licensed physician or facility.

Claims for emergency care

We'll review the information when the claim comes in. If we think the situation was not an emergency, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone. Emergency care expenses that are not related to an emergency medical condition are excluded and are your financial responsibility.

If we don't agree on rates for out-of-network emergency care, Aetna, non-participating physicians and hospitals can file arbitration, known as independent dispute resolution. Your in-network cost share may go up if we need to pay more on an emergency claim if we settle or arbitration is filed after the initial payment.

Follow-up care for plans that require a PCP

Your PCP should coordinate any follow-up care after your emergency. For example, you'll need a doctor to remove stitches or a cast or take another set of X-rays to see if you've healed. You will need a referral for follow-up care that is not performed by your PCP. You may also need to get approval if you go outside the network.

After-hours care

You may call your doctor's office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting participating urgent care facilities.

We check if it's medically necessary

A medically necessary service or supply is one that is provided by a doctor who exercises prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms; the provision of the service or supply is:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease
- Not primarily for your convenience or that of your treating physician
- Not more costly than an alternative service or sequence of services that is at least as likely to produce the same or similar therapeutic or diagnostic results

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Important note: Not every service, supply or prescription drug that fits the definition for medical necessity is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example, some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to your plan documents and Schedule of Benefits for the plan limits and maximums.

All determinations that services are not medically necessary will be made by licensed physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and the same or similar specialty as the health care provider who typically manages your medical condition or disease or provides the health care service under review.

For purposes of a determination involving substance use disorder treatment, services that are not medically necessary will be provided by:

- (i) A physician who possesses a current and valid nonrestricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment
- (ii) A health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid nonrestricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession

We do not reward Aetna employees for denying coverage. Sometimes a physician's group will determine medical necessity. Those groups might use different resources than we do.

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician's group denied coverage. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Or visit [Aetna.com/about/cov_det_policies.html](https://www.aetna.com/about/cov_det_policies.html) to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card.

We study the latest medical technology

We look at scientific evidence published in medical journals to help us decide what is medically necessary. This is the same information doctors use. We also make sure the product or service is in line with how doctors, who usually treat the illness or injury, use it. Our doctors may use nationally recognized resources like MCG (formerly Milliman Care Guidelines).

We also review the latest medical technology, including drugs, equipment and mental health treatments. Plus, we look at new ways to use old technologies.

To make decisions, we may:

- Read medical journals to see the research. We want to know how safe and effective any treatments and technologies are.
- See what other medical and government groups say about treatments and technologies. That includes the federal Agency for Healthcare Research and Quality.
- Ask experts.
- Check how often and how successfully treatments and technologies have been used.

We publish our decisions in our Clinical Policy Bulletins.

How to file a claim

For most services, network doctors will file your claims for you. If you go outside the network, you may need to file claims yourself. Your health care professional may file a claim within 120 days from the date of service. You may also file a claim yourself.

We accept claims by mail, fax and electronically. If you need to file a claim with us, please call Member Services at the number on your Aetna ID card. The representative will give you the mailing address, email address or fax number for our claims office. You can also log in to your member website at [Aetna.com](https://www.aetna.com) to download a claim form (which includes the mailing address) or to send the claim electronically. To send the claim electronically, log in to [Aetna.com](https://www.aetna.com) and click "Contact" in upper right corner. You can submit a claim form as an attachment.

Our plans comply with mental health laws

We want you to know that our plans comply with all federal and NY state requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). This includes the non-quantitative treatment limitation (NQTL) requirements applied to behavioral health and substance use disorder benefits. We use the same processes and standards to determine these requirements as those we use to determine requirements for medical and surgical treatments. In other words, we apply the same medical management requirements, such as precertification, to all plan benefits, including:

- Behavioral health



- Substance use disorder
- Medical and surgical treatments

If you'd like to see how we arrive at the NQTL requirements, we'd be happy to show you our analysis. Just call Member Services at the number on your ID card to request a copy.

How we determine cost share

To ensure that we comply with federal and state mental health laws regarding members' cost share, we apply certain test measures laid out in the federal law. These are called the "substantially all" and "predominant level" tests. If you'd like to see how we arrive at members' cost share, we'd be happy to show you our analysis. Just call Member Services at the number on your ID card to request a copy.

Grievances: What to do if you disagree with us

Please tell us if you are not satisfied with a response you received from us or with how we do business. A grievance is a complaint that does not involve a claim that was denied because it was not medically necessary. It does apply to contractual benefits denials, issues or concerns you have about our administrative policies, or access to doctors.

Here is a summary of the grievance processes.

Call the toll-free number on your Aetna ID card to file a verbal grievance or to ask for the address to mail a written grievance.

You can also email Member Services through the member website or write to us at the address on your Aetna ID card. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

You have the right to appoint a designee to handle your grievance.

You or your designee may file a grievance up to 180 calendar days from when you received the decision you are asking us to review. When we receive your grievance, we will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address and telephone number of the person handling your grievance and indicate what additional information, if any, we need from you.

We keep all requests and discussions confidential and will take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry.

Qualified personnel will review your grievance in a timely manner. If it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the grievance and notify you within the following time frames:

Time frames for determining a grievance

Type of grievance	Level 1 appeals
Expedited/urgent grievance	By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the grievance. We will provide written notice within 72 hours of receipt of your grievance.
Preservice grievance (a request for a service or treatment that has not yet been provided)	In writing, within 15 calendar days of receipt of your grievance
Postservic grievance (a claim for a service or a treatment that has already been provided)	In writing, within 30 calendar days of receipt of your grievance
All other grievances (those that are not in relation to a claim or	In writing, and depending on your plan, either within 30 or 45 calendar days of

request for service)

receipt of your grievance, or within 45
calendar days of receipt of all
Necessary information, but no
More than 60 calendar days
Of receipt of your grievance.
See your plan documents for time
frames that apply to your specific plan.

Grievance appeals

If you are not satisfied with the resolution of your grievance, you or your designee may file an appeal by phone, in person or in writing. You may file an urgent appeal by phone. You have up to 60 business days from receipt of our decision to file an appeal.

When we receive your appeal, we will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address and telephone number of the person handling your appeal. If necessary, it will also inform you of any additional information we may need to make a decision. One or more qualified personnel at a higher level than the person who rendered the complaint decision will review the appeal. If it is a clinical matter, a clinical peer reviewer will look into it.

Time frames for determining your appeal of a grievance determination:

Type of grievance	Level 1 appeals
Expedited/urgent grievance	By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the grievance. We will provide written notice within 72 hours of receipt of your grievance.
Preservice grievance (a request for a service or treatment that has not yet been provided)	The earlier of 2 business days of receipt of all necessary information or 72 hours of receipt of your appeal
Postservice grievance (a claim for a service or a treatment that has already been provided)	30 calendar days of receipt of your appeal
All other grievances (those that are not in relation to a claim or request for service)	Depending on your plan, either 30 business days of receipt of all necessary information to make a determination, or 30 calendar days of receipt of your appeal. See your plan documents for time frames that apply to your specific plan.

If you are not satisfied or if you need help

If you are not satisfied with our appeal determination, or at any other time you are dissatisfied, you may call the New York State Department of Financial Services at **1-800-342-3736** or write them at:

New York State Department of Financial Services Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
dfs.ny.gov

If you need help filing a grievance or appeal, you may also contact the state independent consumer assistance program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010
Call toll-free: 1-888-614-5400
Email: cha@cssny.org
Website: **CommunityHealthAdvocates.org**

Internal appeals for utilization review determinations

You have the right to appoint a designee to handle your appeal. You, your designee and, in retrospective cases, your doctor, may request an internal appeal if we deny a previously precertified service or make other adverse determinations based on utilization review. You may submit your appeal by phone, in person or in writing. You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before we can make a decision. A qualified clinical peer reviewer who is a physician or a health care professional in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

First-level appeal Precertification appeal

If your appeal relates to a service that requires prior approval and the services have not yet been rendered, we will decide the appeal within 15 calendar days of receipt of the appeal request.

Retrospective appeal

If your appeal relates to a retrospective claim, we will decide the appeal within 30 calendar days of receipt of the appeal request.

Expedited appeal

An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited appeal is not available for retrospective reviews. For an expedited appeal, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited appeal will be determined within the earlier of 72 hours of receipt of the appeal or two business days of receipt of the information necessary to conduct the appeal.

If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

Our failure to render a determination of your appeal within the applicable time frame will be deemed a reversal of the initial adverse determination.

Substance use disorder appeal

If we deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and you or your provider file an expedited internal appeal of our adverse determination, we will decide the appeal within 24 hours of receipt of the appeal request.

If you or your provider file the expedited internal appeal and an expedited external appeal within 24 hours of receipt of our adverse determination, we will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal appeal and external appeal is pending.

Second-level appeal

If you disagree with the first-level appeal determination, you or your designee can file a second-level appeal. You or your designee can also file an external appeal. The four-month time frame for filing an external appeal begins on receipt of the final adverse determination on the first level of appeal. By choosing to file a second-level appeal, the time may expire for you to file an external appeal.

A second-level appeal must be filed within 60 days of receipt of the final adverse determination on the first-level appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and phone number of the person handling your appeal and inform you, if necessary, of any additional information needed before a decision can be made.

If your appeal relates to a service that requires prior approval and the services have not yet been rendered, we will decide the appeal within 15 calendar days of receipt of the appeal request. If your appeal relates to a retrospective claim, we will decide the appeal within 30 calendar days of receipt of the appeal request.

If your doctor thinks you cannot wait, you can request an expedited appeal

If you are not satisfied with the resolution of an expedited appeal, you may file a standard internal appeal or an external appeal. You may file an expedited external appeal at the same time you file an expedited internal appeal. See the "External review" section for more.

External appeal

A. Your right to an external appeal

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals. In order for You to be eligible for an external appeal, You must meet the following two (2) requirements:

- The service, procedure or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
 - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
 - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your right to appeal a determination that a service is not medically necessary

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your right to appeal a determination that a service is experimental or investigational

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

- (1) Standard health services are ineffective or medically inappropriate; or
 - (2) There does not exist a more beneficial standard service or procedure Covered by Us;
- or



- (3) There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

- (1) A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation — Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
- (2) A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- (3) A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your right to appeal a determination that a service is out-of-network

If We have denied coverage of an out-of-network treatment because it is not materially different from the health service available in network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service and, based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment; and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your right to appeal an out-of-network referral denial to a non-participating provider

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. Your right to appeal a formulary exception denial

If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Certificate for more information on the formulary exception process.

G. The external appeal process

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an



external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at **1-800-400-8882**. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 72 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug.

If Your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 24 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within 72 hours of receipt of Your completed application.

If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of your Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under your Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge You a fee of \$25 for each external appeal, not to exceed \$75 in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

H. Your responsibilities

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

Your rights to enroll later if you decide not to enroll now

When you lose your other coverage

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 60 days after your coverage ends (or after the employer stops contributing to the other coverage).

When you have a new dependent

Getting married? Having a baby? A new dependent changes everything. And you can change your mind. You can enroll within 60 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

Talk to your benefits administrator for more information or to request special enrollment.

More information is available upon request

In accordance with New York law, the following information is available to a member or prospective member upon request by contacting the Member Services department:

- (1) A list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners
or partners of the plan
- (2) The most recent certified financial statements of the plan, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant
- (3) A copy of the most recent individual conversion, direct-pay subscriber contracts

- (4) Information relating to consumer complaints compiled pursuant to Section 210 of the New York insurance law
- (5) Procedures for protecting the confidentiality of medical records and other enrollee information
- (6) Drug formularies, if any, used by the plan and the inclusion/exclusion of individual drugs
- (7) Written description of the organizational arrangements and ongoing procedures of the plan's quality assurance program
- (8) A description of the procedures followed in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials
- (9) Individual health practitioner affiliations with participating hospitals, if any
- (10) Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information the plan might consider in its patient management program; the plan may include with the information a description of how it will be used in the patient management process, provided, however, that to the extent such information is proprietary to the plan, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the plan.

Member Services can help you with this request by calling the number on your Aetna ID card. You can also send a request to Aetna by writing to:

Aetna

Attn: CRC Requests 1800 E Interstate Ave
Bismarck, ND 58503

- (11) Written application procedures and minimum qualification requirements for health care providers considered by the plan
- (12) Such other information as required by the Superintendent of Insurance provided that such requirements are promulgated pursuant to the state administrative procedure act
- (13) If you are scheduled to receive health care services, you can ask us if that health care provider participates in the plan's network
- (14) The approximate dollar amount the plan will pay for a specific out-of-network health care service. This information is nonbinding and the approximate dollar amount for a specific out-of-network service may change.

Protection from surprise bills

A surprise bill is a bill you receive for covered services performed by a nonparticipating physician at a participating hospital or ambulatory surgical center, when:

- A participating physician is unavailable at the time the health care services are performed
- A nonparticipating physician performs services without your knowledge
- Unforeseen medical issues or services arise at the time the health care services are performed
- You were referred by a participating physician to a nonparticipating provider without your explicit written consent acknowledging that the referral was to a nonparticipating provider and that the visit may result in costs not covered by us (a referral to a nonparticipating provider is defined as covered services performed by a nonparticipating provider in the participating physician's office or practice during the same visit)
- The participating physician sends a specimen taken from you in the participating physician's office to a nonparticipating laboratory or pathologist
- For any other covered services performed by a nonparticipating provider at the participating physician's request, when referrals are required under your certificate

- A surprise bill does not include a bill for health care services when a participating physician is available and you elected to receive services from a nonparticipating physician.
- You will be held harmless for any nonparticipating provider charges for the surprise bill that exceed your in-network copayment, deductible or coinsurance if you assign benefits to the nonparticipating provider in writing. In such cases, the nonparticipating provider may only bill you for your in-network copayment, deductible or coinsurance.
- The assignment of benefits form for surprise bills is available on the next page or at **dfs.ny.gov**. You can also visit our website at **Aetna.com** for a copy of the form. You need to mail a copy of the assignment of benefits form to us at the address on your ID card and to your provider.
- You can call Member Services if you need help completing and sending the form. The phone number is on your Aetna ID card. You may mail the form to us at:

Member Correspondence Aetna
PO Box 981106
El Paso, Texas 79998-1106

Or you can send the form electronically. Log in to

Aetna.com and click "Contact" in the upper right corner. You can submit the form as an attachment.

Independent dispute resolution process:

Either we or a provider may submit a dispute involving a surprise bill to an independent dispute resolution entity (IDRE) assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at **dfs.ny.gov**. The IDRE will determine whether our payment or the provider's charge is reasonable within 30 days of receiving the dispute. You may also submit a dispute if you do not assign benefits or if you are uninsured.

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits form

Use this form if you receive a surprise bill for health care services and want the services to be treated as in network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at **1-800-342-3736**.

A surprise bill is when:

1. You received services from a nonparticipating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a nonparticipating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a nonparticipating physician instead of from an available participating physician; OR
2. You were referred by a participating physician to a nonparticipating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a nonparticipating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a nonparticipating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Patient Name: _____

Patient Address: _____

Insurer Name: _____

Patient Insurance ID No.: _____

Provider Name: _____ Provider Telephone Number: _____

Provider Address: _____

Date of Service: _____

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



(Signature of patient)

(Date of signature)

NYS FORM OON-AOB (5/26/15)

Out-of-network reimbursement examples for large group coverage

This summary gives examples of typical costs for out-of-network services under our three most commonly sold health insurance plans in New York County that include ZIP codes with the prefix 100, 101 and 102. If you want details about your coverage and costs, you can get the complete terms in the policy or plan document by calling **1-888-982-3862**.

Colonoscopy CPT4 codes

Procedure: 45380

Anesthesia: 00810

Pathology: 88305

	UCR charge	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Hospital services	\$5,119	\$3,916	\$1,827	\$1,827
Physician services	\$1,600	\$750	\$350	\$275
Anesthesia	\$1,944	\$417	\$191	\$150
Pathology	\$263	\$244	\$114	\$89
Total	\$8,926	\$5,326	\$2,482	\$2,342

Patient pays	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Deductible	\$2,000	\$2,000	\$2,000
Copays	\$50	\$50	\$50
Coinsurance	\$983	\$130	\$88
Difference between UCR charge and what the plan pays	\$6,632	\$8,623	\$8,722
Total	\$9,665	\$10,803	\$10,859

Laminotomy CPT4 codes

Procedure: 63030

Anesthesia: 00630

	UCR charge	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Hospital services	\$18,250	\$3,158	\$1,474	\$1,474
Physician services	\$35,000	\$3,859	\$1,801	\$1,415
Anesthesia	\$6,600	\$1,668	\$764	\$600
Total	\$59,850	\$8,685	\$4,039	\$3,489

Patient pays	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Deductible	\$2,000	\$2,000	\$2,000
Copays	\$50	\$50	\$50
Coinsurance	\$1,990	\$597	\$432
Difference between UCR charge and what the plan pays	\$55,206	\$58,458	\$58,843
Total	\$59,246	\$61,105	\$61,325

Breast Reconstruction CPT4

codes Procedure: 19357

Anesthesia: 00402

	UCR charge	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Hospital services	\$64,501	\$62,486	\$29,160	\$29,160
Physician services	\$21,280	\$5,616	\$2,621	\$2,059
Anesthesia	\$4,596	\$1,137	\$521	\$409
Total	\$90,377	\$69,239	\$32,302	\$31,629

Patient pays	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Deductible	\$2,000	\$2,000	\$2,000
Copays	\$50	\$50	\$50
Coinsurance	\$20,157	\$9,076	\$8,874
Difference between UCR charge and what the plan pays	\$12,818	\$38,674	\$39,145
Total	\$35,024	\$49,799	\$50,068

The usual, customary and reasonable (UCR) charge is the amount providers typically charge for a service. This chart uses UCR charges based on FAIR Health at the 80th percentile for New York County ZIP codes with the prefix 100. Your provider may bill more than the UCR charge.

The "patient pays" column represents sample cost-sharing. Your cost-sharing may vary.

Notes: Colonoscopy provided out of network is not covered as a preventive service under the Affordable Care Act. Copayment is shown as \$0 because copayments do not typically apply to out-of-network coverage.

These examples do not take into account whether the member's coinsurance is 30% and assumes the member's coinsurance limit has been met.

These examples only apply to plans with out-of-network coverage.

Claim examples assume services were done on an outpatient basis.

Sample cost examples:

Plan A = 300% Medicare for professional services, and 300% Medicare facility services

Plan B = 140% Medicare for professional services, and 140% Medicare facility services

Plan C = 110% Medicare for professional services, and 140% Medicare facility services

These samples were prepared in December 2019. UCR charges may change over time.

Aetna complies with applicable federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462,
Lexington, KY 40512
(CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: **859-425-3379** (CA HMO customers: **860-262-7705**).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697 (TDD)**

TY: 711

To access language services at no cost to you, call 1-888-982-3862 .

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. (Spanish)

如欲使用免費語言服務, 請致電 1-888-982-3862 。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862 . (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

(Arabic) .1-888-982-3862

مقرلا بلع لامتلا ءاجرلا ،تفلك يا نود تيوغلا تامدخلا بلع لوصحل

Pou jwenn sèvis lang gratis, rele 1-888-982-3862. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862 . (Italian)

言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. (Korean)

دیریگ سامت 1-888-982-3862 هرامش اب ،ناگیار روط هب نابز تامدخ هب پسرئسد یارب. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862 .

(Polish) Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862 .

(Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862 . (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862 . (Vietnamese)

Confidentiality Notice

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

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

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

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.