

# BENEFIT PLAN

Prepared Exclusively For  
Pace University

Open Access Elect Choice Extraterritorial Riders

Extraterritorial  
Riders

**Aetna Life Insurance Company**

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



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# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

**Important note:** The following apply only if you live in Arizona. The benefits below will apply instead of those in your booklet-certificate.

### Notice

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

### When you are injured

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

### The difference between a complaint and an appeal

#### Complaint

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

#### Appeal

The appeal process information packet explains all of your appeal rights. We sent you a copy of this. If you need another copy you can obtain one by calling us. When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

## Claim decisions and appeal procedures

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

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

## Appeal of an adverse benefit determination

### Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

### Any other claim appeal

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

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

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

## Exhaustion of appeal process

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

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

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

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of Arizona or federal Department of Health and Human Services.

## External review

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

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

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

## IRO decisions

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

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

## Utilization review

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

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

## Recordkeeping

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

## Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

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



Dan Finke

President  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Arizona Medical ET  
Issue Date: February 2, 2022

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

**Important note:** The following apply only if you live in California. The benefits below will apply instead of those in your booklet-certificate.

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

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

- Your legal spouse
- Your civil union partner
- Your domestic partner

### Routine cancer screenings

**Eligible health services** include routine cancer screenings which also include:

- Cervical cancer screenings

### Osteoporosis

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

### Anesthesia and hospital charges for dental care

**Eligible health services** include anesthesia for dental care only if you have a condition that requires that a dental procedure be done in a **hospital** or outpatient **surgery center** and you are:

- Under 7 years old
- Developmentally disabled (at any age)
- In poor health and have a medical need for general anesthesia (at any age)



## Comprehensive infertility services

**Eligible health services** include comprehensive **infertility** care. 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:

- You are covered under this plan as an employee or as a covered dependent who is the employee’s legal spouse or domestic partner, referred to as “your partner”.
- 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 or your partner 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.
- You or your partner do not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- 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.
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

<b>You are</b>	<b>Number of months of unprotected timed sexual intercourse:</b>	<b>Number of donor artificial insemination cycles: Self paid/not paid for by plan</b>	<b>You need to have an unmedicated day 3 FSH test done within the past:</b>	<b>The results of your unmedicated day 3 FSH test:</b>
A female under 35 years of age with a male partner	A. 12 months or more   or	B. At least 12 cycles of donor insemination	12 months	Must be less than 19 mIU/mL in your most recent lab test
A female under 35 years of age without a male partner	Does not apply	At least 12 cycles of donor insemination	12 months	Must be less than 19 mIU/mL in your most recent lab test
A female 35 years of age or older with a male partner	A. 6 months or more   or	B. At least 6 cycles of donor insemination	6 months	<b>If you are less than age 40</b> , must be less than 19 mIU/mL in your most recent lab test  <b>If you are age 40 and older</b> , must be less than 19 mIU/mL in all prior

				tests performed after age 40
A female 35 years of age or older without a male partner	Does not apply	At least 6 cycles of donor insemination	6 months	<p><b>If you are less than age 40</b>, must be less than 19 mIU/mL in your most recent lab test</p> <p><b>If you are age 40 and older</b>, must be less than 19 mIU/mL in all prior tests performed after age 40</p>
A male of any age with a female partner under 35 years of age	12 months or more	Does not apply	Does not apply	Does not apply
A male of any age with a female partner 35 years of age or older	6 months or more	Does not apply	Does not apply	Does not apply

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 an **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

**Eligible health services** include Assisted Reproductive Technology (ART). ART services are more advanced medical procedures or treatments performed to help a woman achieve pregnancy.

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 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 treatment for medical conditions that will result in infertility.
- 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 or your partner has 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.
- You or your partner does not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- 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 a 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.
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

You are	Number of months of unprotected timed sexual intercourse:	Number of donor artificial insemination cycles: Self paid/not paid for by plan	You need to have an unmedicated day 3 FSH test done within the past:	The results of your unmedicated day 3 FSH test:
A female under 35 years of age with a male partner	A. 12 months or more or 	B. At least 12 cycles of donor insemination	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.

A female under 35 years of age without a male partner	Does not apply	At least 12 cycles of donor insemination	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.
A female 35 years of age or older with a male partner	<p>A. 6 months or more</p> <p>or</p> 	B. At least 6 cycles of donor insemination	6 months	<p><b>If you are less than age 40</b>, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.</p> <p><b>If you are age 40 and older</b>, must be less than 19 mIU/mL in all prior tests performed after age 40 to use your own eggs, embryos or donor eggs or embryos.</p>
A female 35 years of age or older without a male partner	Does not apply	At least 6 cycles of donor insemination	6 months	<p><b>If you are less than age 40</b>, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.</p> <p><b>If you are age 40 and older</b>, must be less than 19 mIU/mL in all prior tests performed after age 40 to use</p>

				your own eggs, embryos or donor eggs or embryos.
A male of any age with a female partner under 35 years of age	12 months or more	Does not apply	Does not apply	Does not apply
A male of any age with a female partner 35 years of age or older	6 months or more	Does not apply	Does not apply	Does not apply

- If you have been diagnosed with premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services through age 45 regardless of FSH level.

### 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 infertile
- 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**

The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below:

You are	You need to have an unmedicated day 3 FSH test done within the past:	The results of your unmedicated day 3 FSH test:
A female under 35 years of age	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs.
A female 35 years of age or older	6 months	<b>If you are less than age 40</b> , must be less than 19 mIU/mL in your most recent lab test.  <b>If you are age 40 and older</b> , must be less than 19 mIU/mL in all prior tests performed after age 40.

**Eligible health services** for fertility preservation will be paid on the same basis as other ART services benefits for individuals who are **infertile**.

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 an 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 service 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.

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: California Medical ET  
Issue Date: February 2, 2022

## **Additional Information Provided by Aetna Life Insurance Company**

### **Inquiry Procedure**

The plan of benefits described in the Booklet-Certificate is underwritten by:

**Aetna Life Insurance Company (Aetna)**  
**151 Farmington Avenue**  
**Hartford, Connecticut 06156**

**Telephone: (860) 273-0123**

**If you have questions about benefits or coverage under this plan, call Member Services at the number shown on your Identification Card. You may also call Aetna at the number shown above.**

**If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the Consumer Service Division of the Department of Insurance at:**

300 South Spring Street  
Los Angeles, CA 90013  
<https://www.insurance.ca.gov/01-consumers/101-help/index.cfm>

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

### **Participating Providers**

We want you to know more about the relationship between Aetna Life Insurance Company and its affiliates (Aetna) and the participating, independent providers in our network. Participating physicians are independent doctors who practice at their own offices and are neither employees nor agents of Aetna. Similarly, participating hospitals are neither owned nor controlled by Aetna. Likewise, other participating health care providers are neither employees nor agents of Aetna.

Participating Providers are paid on a 'Discounted Fee For Service' arrangement. Discounted fee for service means that participating providers are paid a predetermined amount for each service they provide. Both the participating provider and Aetna agree on this amount each year. This amount may be different than the amount the participating provider usually receives from other payers.

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

**Important note:** The following apply only if you live in Colorado. The benefits below will apply instead of those in your booklet-certificate.

### Cleft Palate and Cleft Lip Conditions

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

Services and supplies include:

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

### Clinical trials

#### Routine patient costs

**Covered services** include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial for a disabling, progressive or other life-threatening disease or condition, as defined and amended under the September 19, 2000 Medicare national coverage decision regarding clinical trials and all of the following conditions are met:

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

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

The following are not **covered services**:

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

### **Experimental or investigational therapies**

**Covered services** include drugs, devices, treatments, or procedures from a **provider** under an “approved clinical trial” only when you have a disabling, progressive or other life-threatening disease or condition, as defined and amended under the September 19, 2000 Medicare national coverage decision regarding clinical trials.

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

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

### **Early intervention services**

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

**Covered services** include:

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

### **Maternity and related newborn care**

**Covered services** include pregnancy (prenatal), **complications of pregnancy** care, care after delivery and obstetrical services. After your child is born, **covered services** include:

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

**Covered services** also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

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

### **Nutritional support**

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

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

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

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

## Vision care

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

## Complications of pregnancy

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

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

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

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

A percentage paid by a covered person for a **covered service**.

## Telemedicine

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

- Two-way audiovisual teleconferencing
- Any other method required by law

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





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

Amendment: Colorado Medical ET  
Issue Date: February 2, 2022

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

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

### Precertification

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

### How COB works with Medicare

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



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

Amendment: Connecticut Medical ET  
Issue Date: February 2, 2022

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

**Important note:** The following apply only if you live in Delaware. The benefits below will apply instead of those in your booklet-certificate.

Inpatient stays in a **hospital** or **residential treatment facility** for **substance abuse** related disorders will not require **precertification**.

### Routine cancer screenings

**Eligible health services** include the following routine cancer screenings:

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

These benefits will be subject to any age, family history and frequency guidelines that are:

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

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

### Autism spectrum disorder

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

**Eligible health services** include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.

Eligible health services include:

- Behavioral health treatment
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care
- Items and equipment necessary to provide, receive, or improve upon any of the above listed services, including those necessary for Applied Behavior Analysis.

Any care for autism spectrum disorders that is determined by the Secretary of the Department of Health and Social Services, based upon their review of best practices and/or evidence-based research, to be medically necessary.

We will cover early intensive behavioral interventions such as applied behavior analysis.

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

- That systematically change behavior, and
- That is responsible for observable improvements in behavior.

## **Diabetic equipment, supplies and education**

**Eligible health services** include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin preparations
  - Diabetic needles and syringes
  - Injection aids for the blind
  - Diabetic test agents
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
- Equipment
  - External insulin pumps
  - Blood glucose monitors without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

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

## **Infertility services**

### **Basic infertility**

**Covered services** include seeing a **provider**:

- To diagnose and evaluate the underlying medical cause of **infertility**.

- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.

### **Comprehensive infertility services**

**Covered services** include the following **infertility** services provided by an **infertility specialist**:

- Ovulation induction cycle(s) while on injectable medication to stimulate the ovaries
- Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination

**Infertility covered services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan. For plans with cycle limits, a “cycle” is defined as:

- An attempt at ovulation induction while on injectable medication to stimulate the ovaries with or without artificial insemination
- An artificial insemination cycle with or without injectable medication to stimulate the ovaries

You are eligible for these **covered services** if:

- You or your partner have been diagnosed with **infertility**
- You have met the requirement for the number of months trying to conceive through egg and sperm contact
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna’s **infertility** clinical policy

### **Aetna’s National Infertility Unit**

The first step to using your comprehensive **infertility covered services** is enrolling with our National Infertility Unit (NIU). Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators. They can help you with determining eligibility for benefits. They can also help your **provider** with **precertification**. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your **infertility** services.

### **Advanced reproductive technology (ART)**

Advanced reproductive technology (ART), also called “assisted reproductive technology”, is a more advanced type of **infertility** treatment. **Covered services** include the following services provided by a **network ART specialist**:

- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you 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 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. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)

ART **covered services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan. For plans with cycle limits, an ART “cycle” is defined as:

Procedure	Cycle count
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Procedure	Cycle count
One complete fresh IVF cycle with transfer (egg retrieval, fertilization, and transfer of embryo)	One full cycle
One fresh IVF cycle with attempted egg aspiration (with or without egg retrieval) but without transfer of embryo	One-half cycle
Fertilization of egg and transfer of embryo	One-half cycle
One cryopreserved (frozen) embryo transfer	One-half cycle
One complete GIFT cycle	One full cycle
One complete ZIFT cycle	One full cycle

You are eligible for ART services if:

- You or your partner have been diagnosed with **infertility**
- You have exhausted comprehensive **infertility** services benefits or have a 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
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna's **infertility** clinical policy

### **Aetna's National Infertility Unit**

The first step to using your ART **covered services** is enrolling with our National Infertility Unit (NIU). Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators. They can help you with determining eligibility for benefits and can give you information about our **infertility** Institutes of Excellence™ facilities. They can also help your **provider** with **precertification**. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your **infertility** services.

### **Fertility preservation**

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

**Covered services** for fertility preservation are provided when:

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

### **Premature ovarian insufficiency**

If your **infertility** has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services if egg retrievals are completed before you reach age 45 and transfers are completed before you reach age 50 regardless of FSH level.

The following are not **covered services**:

- Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm or reproductive tissue.

- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when a successful pregnancy could have been obtained through less costly treatment.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, 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.
- **Infertility** treatment when **infertility** is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's **infertility** clinical policy.
- Treatment for dependent children, except for fertility preservation as described above.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

## Scalp hair prosthesis

**Eligible health services** include coverage for scalp hair prosthesis worn for hair loss resulting from alopecia areata, resulting from an autoimmune disease. Coverage is subject to the same limitations and guidelines as other prosthesis as listed in the *exceptions* section.

## Contraceptives

Unless your Plan has an approved religious exemption, the calendar year/plan year **deductible**, any **prescription drug deductible** and the per **prescription copayment/coinsurance** will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that the following will be paid at 100%:

- Certain over-the counter (OTC) and generic contraceptive **prescription drugs** and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drugs** for that method paid at 100%.
- We provide coverage for a supply of prescribed contraceptives intended to last over a 12-month duration. The prescribed contraceptive **prescription drug** may be filled all at once or over the course of the 12-month as prescribed by your provider.

## Types of claims and communicating our claim decisions

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

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

### Urgent care claim

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

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

### Pre-service claim

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

### Post-service claim

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

### Concurrent care claim extension

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

### Concurrent care claim reduction or termination

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

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

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	72 hours	15 days	30 days	24 hours for urgent request*  15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (us)	48 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

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



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

A handwritten signature in black ink, appearing to read 'Dan Finke', with a long horizontal stroke extending to the right.

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

Amendment: Delaware Medical ET  
Issue Date: February 2, 2022



# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

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

- Dependent children – yours or your spouse’s also include those:
  - Under 26 years of age
    - A dependent child who is under 26 years of age will be covered until the end of the calendar year after they have reached age 26
    - A dependent child from the end of the calendar year in which the child turns age 26 until the end of the calendar year in which the child turns age 30, provided the child is:
      - Unmarried
      - A resident of Florida or a full-time or part-time student
      - Not eligible for Medicare and not covered under another group or individual health benefit plan

### Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, you will be responsible for any additional premium charges due effective from the date of birth.
- A newborn child of a covered dependent other than your spouse is covered for 18 months. At the end of 18 months coverage the newborn will be terminated. You must enroll the newborn within 60 days of the date of birth
- 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 from the moment of placement in your residence. In the case of an adopted newborn child, the child is covered for the first 31 days from the moment of birth
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the adoption.
  - If you miss this deadline, you will be responsible for any additional premium charges due effective from the date of adoption.
- 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 group health plan of any covered dependent

### **Routine physical exams**

**Eligible health services** include office visits to your **physician, PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk human papillomavirus (HPV) DNA testing for women age 30 and older
- Radiological services, lab and other tests given in connection with the exam.
- Child Health Supervision Services for children from birth through age 16, including a physical

examination, developmental assessment; anticipatory guidance, appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

- For covered newborns, an initial **hospital** checkup.

## Routine cancer screenings

**Eligible health services** include the following routine cancer screenings:

- Mammograms: age 35 to 39, one baseline mammography; age 40 and older, one routine mammography every year; or one or more mammograms a year, based upon a Physician's recommendation for any woman:
  - who is at risk for breast cancer because of a personal or family history of breast cancer,
  - having a history of biopsy-proven benign breast disease,
  - having a mother, sister, or daughter who has had breast cancer, or
  - who has not given birth before the age of 30
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

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

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

## Autism spectrum disorder

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

**Eligible health services** include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.

We will cover certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That is responsible for observable improvements in behavior.

### Important note:

Applied behavior analysis requires **precertification** by Aetna. The **network provider** is responsible for obtaining **precertification**. You are responsible for obtaining **precertification** if you are using an

**out-of-network provider.**

<b>Autism spectrum disorder</b>	
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other <b>illness</b> under this plan	

### **Birthing center**

**Eligible health services** include 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
- Services rendered by a certified nurse midwife, licensed midwife or birthing center in connection with childbirth

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.

### **Jaw joint disorder treatment**

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

### **Cleft lip and palate**

**Eligible health services** include treatment given to a dependent child under age 18 for a congenital cleft lip or cleft palate. This includes:

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

### **Maternity and related newborn care**

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

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- Services rendered by a certified nurse midwife, licensed midwife or birthing center in connection with childbirth.

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

## Reconstructive surgery 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** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses.
- 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.

**Eligible health services** for reconstructive breast surgery includes:

- The appropriate period of necessary inpatient care determined by your physician.
- Outpatient follow-up care as determined by your physician.

## Mastectomy Reconstruction And Prosthetic Expense

**Eligible health services** include charges incurred for Mastectomy Reconstruction and Prosthetic Expense charges incurred incident to a mastectomy for:

- the initial prosthetic device; and
- reconstructive **surgery**.

## Habilitation therapy services (for autism spectrum disorder and Down Syndrome treatment only)

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, speech therapy and applied behavior analysis

**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).

## **Dermatological Services**

**Eligible health services** include Dermatological Services and dermatological office visits for minor procedures and testing. Services or testing not considered minor or routine in nature may require **precertification**.

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

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

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

## **Why would we end you and your dependents coverage?**

We will give you 45 days advance written notice if we end your coverage because:

- You do not cooperate or give facts that we need to administer the *COB* provisions.
- You commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *A bit of this and that - Honest mistakes and intentional deception* section for more information on rescissions.

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

## **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 in “Why we would end your coverage”).

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.

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: Florida Medical ET  
Issue Date: February 2, 2022





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

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

**Important note:** The following apply only if you live in Illinois. The benefits below will apply instead of those in your booklet-certificate.

### Preventive care immunizations

**Eligible health services** include immunizations provided by your **physician, PCP** or other **health professional** for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Doses, recommended ages and recommended population vary.

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

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

## Well woman preventive visits

**Eligible health services** include your routine:

- Well woman preventive exam office visit to your **physician, PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes annual pap smears including ovarian cancer surveillance tests for woman at risk of ovarian cancer. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness or injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.
- Clinical breast exams as follows:
  - For women over 20 years of age but less than 40, at least every 3 years
  - For women 40 years of age and older, annually.
- Breast cancer chemoprevention counseling.
- Cervical cancer screening for sexually active woman.
- Chlamydia infection screening for younger women and other women at higher risk.
- HIV screening and counseling for sexually active woman.
- Osteoporosis screening for women over age 60 depending on risk factors.

**Eligible health services** for pregnant or women who may become pregnant include:

- Anemia screening on a routine basis
- Folic acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening
- Urinary tract or other infection screening.

## Maternity and related newborn care

**Eligible health services** include prenatal (including prenatal HIV testing) and postpartum care and obstetrical services. After your child is born, **eligible health services** include:

- 48 of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier. If discharged earlier, to verify the condition of the infant, a **physician** office visit or an in home nurse visit within 48 hours after discharge is available
- The mother could be discharged earlier. If so, the plan will pay for 1 post-delivery home visits by a health care **provider**.

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

## Elective Abortion

Unless coverage is provided under a policy issued in the state of Indiana, Idaho, Michigan, Texas or Utah, covered services also include the services and supplies provided for the voluntary termination of a pregnancy performed by a health professional.

## Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, physical complications of all stages of the mastectomy, including lymphedema and prostheses. It also includes a **physician** office visit or in home nurse visit within 48 hours after discharge.
- 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.

## Court-ordered treatment of substance abuse disorders

Your plan covers court-ordered U.S. FDA approved **prescription drugs** for the treatment of **substance use disorders** and any associated counseling or wraparound services.

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

## Claim procedures

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none"> <li>• You should notify and request a claim form from the policyholder.</li> <li>• The claim form will provide instructions on how to complete and where to send the form(s).</li> </ul>	<ul style="list-style-type: none"> <li>• You must send us notice and proof as soon as reasonably possible.</li> <li>• If you are unable to complete a claim form, you may send us:               <ul style="list-style-type: none"> <li>- A description of services</li> <li>- Bill of charges</li> <li>- Any medical documentation you received from your provider</li> </ul> </li> </ul>
Proof of loss (claim)	<ul style="list-style-type: none"> <li>• A completed claim form and any additional information required by us.</li> </ul>	<ul style="list-style-type: none"> <li>• You must send us notice and proof as soon as reasonably possible.</li> </ul>
Benefit payment	<ul style="list-style-type: none"> <li>• Written proof must be provided for all benefits.</li> <li>• If any portion of a claim is contested by us, the uncontested portion of the</li> </ul>	<ul style="list-style-type: none"> <li>• Benefits will be paid within 30 days after the necessary proof to support the claim is received.</li> </ul>

	<p>claim will be paid promptly after the receipt of proof of loss.</p>	<ul style="list-style-type: none"> <li>• If benefits are not paid within 30 days after proof of loss is received, you are entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than \$1 may not be paid.</li> </ul>
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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: Illinois Medical ET  
 Issue Date: February 2, 2022

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

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

### 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
- Your dependent children – your own or those of your spouse or domestic partner
  - The children must be under 26 years of age, and they include:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
    - Grandchildren in your court-ordered custody
    - A grandchild whose parent is already covered as a dependent under this plan
    - Any other child with whom you have a parent-child relationship
    - Any child placed in your home due to the execution of an act of voluntary surrender

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

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.

### Well woman preventive visits

**Eligible health services** include your routine:

- Well woman preventive exam office visit to your **physician**, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes annual pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness or injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

<b>Well woman preventive visits routine gynecological exams (including annual pap smears)</b>	
Performed at a <b>physician's</b> , obstetrician (OB), gynecologist (GYN) or OB/GYN office	0% per visit  No <b>deductible</b> applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit

### **Routine cancer screenings**

**Eligible health services** include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal immunochemical test (FIT)
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
- Current recommendations established by the American College of Gastroenterology (ACOG) in consultation with the American Cancer Society

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



<b>Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)</b>	
<b>Mammograms</b> Baseline mammogram (one baseline mammogram, for a female age 35 but less than age 40; one mammogram every 12-24 months or more frequently if recommended by the person's physician, for a female age 40 but less than age 50; and one mammogram every 12 months for a female age 50 or over)	0% per visit  No <b>deductible</b> applies
<b>Prostate specific antigen (PSA) test and Digital rectal exam (DRE)</b>	0% per visit  No <b>deductible</b> applies
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>• The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> For details, contact your <b>physician</b> or Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.
<b>Colonoscopies</b>  One every 10 years beginning at age 50 (or age 45 for African Americans)	0% per visit  No <b>deductible</b> applies
<b>Sigmoidoscopies</b>	0% per visit  No <b>deductible</b> applies
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>• The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> For details, contact your <b>physician</b> or Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.

Fecal Immunochemical Test for blood (FIT)	0% per visit  No <b>deductible</b> applies
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>• The comprehensive guidelines supported by the Health Resources and Services Administration.</li> <li>• Current recommendations established by the American College of Gastroenterology (ACOG) in consultation with the American Cancer Society.</li> </ul> <p>For details, contact your <b>physician</b> or Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.</p>
Other routine cancer screening	0% per visit  No <b>deductible</b> applies
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>• The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> <p>For details, contact your <b>physician</b> or Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.</p>
Lung cancer screening maximums	1 screenings every 12 months*
<p><b>*Important note:</b> Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.</p>	

**Acupuncture**

**Covered services** include **medically necessary** acupuncture services provided by a **health professional**.

The following are not **covered services**:

- Acupressure

### **Anesthesia for certain dental procedures**

**Eligible health services** include services for general anesthesia and associated **hospital** care in connection with dental care. Your treating dentist will determine if you have a mental or physical condition that requires you to receive the dental treatment in a **hospital** setting. Your dentist will determine this by following anesthesia guidelines in the reference manual of the American Academy of Pediatric Dentistry.

We cover these services on the same basis as any other **illness** or **injury**.

Anesthesia for certain dental procedures does not include services:

- incurred for the treatment of temporomandibular joint disorder (TMJ)
- furnished by a **provider** who is not an accredited dentist in pediatric dentistry or in a dental specialty that has **hospital** privileges.

### **Autism spectrum disorder**

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

**Eligible health services** include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of Autism Spectrum Disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.

We will cover early intensive behavioral interventions such as Applied Behavior Analysis. Applied Behavior Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That are responsible for observable improvements in behavior.

<b>Autism spectrum disorder</b>	
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received.
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received.
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received.
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other <b>illness</b> under this plan.	

### **Cleft lip and cleft palate**

**Eligible health services** include services and supplies for:

- Oral and facial surgery, including care by a **physician** before and after surgery
- Oral prosthesis
- Installation of dentures
- Replacement of dentures, fixed bridgework, or fixed partial dentures because of growth, resulting in structural changes in the mouth or jaw
- Cleft orthodontic therapy
- Orthodontic, otolaryngology or prosthetic treatment and management
- Installation of crowns
- Diagnostic **physician** services to find out the extent of loss in your ability to speak or hear
- Speech therapy by a **physician** to overcome congenital or early acquired disabilities
- Rehabilitative speech therapy (including speech aids and training) by a **physician** to restore or improve your ability to speak
- Psychological assessment and counseling
- Genetic assessment and counseling for your dependent child and both parents
- Hearing aids
- Hearing loss assessment, treatment and management, including surgically implanted amplification devices
- Physical therapy assessment and treatment
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy

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

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

Unless provided above, the following are not covered under your plan:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended
- Services to treat delays of speech development unless these delays are caused by cleft lip or cleft palate or any condition related to or developed as a result of cleft lip or cleft palate
- Speech aids and training in the use of speech aids
- Training in the use of communication systems that are used in the special education of a person who has problems speaking or hearing – for example lessons in sign language would not be covered

## Diabetic equipment, services, supplies and outpatient self-management training and education

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin preparations
  - Diabetic needles and syringes
  - Injection aids for the blind
  - Diabetic test agents
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
  - Medical nutritional therapy
- Equipment
  - External insulin pumps
  - Blood glucose monitors without special features, unless required due to blindness
- Outpatient self-management training and education

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

<b>Diabetic equipment, services, supplies and outpatient self-management training and education</b>	
Diabetic equipment, services, supplies and outpatient self-management training and education	Covered according to the type of benefit and the place where the service is received.

## Maternity and related newborn care

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

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- If your physician recommends that your stay be extended, additional days will need to be precertified. See the Precertification section on how to obtain this precertification.
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier. If so, the plan will pay for 2 post-delivery home visits by a health care **provider**.

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

## Pregnancy complications

**Eligible health services** include services and supplies from your **provider** for pregnancy complications.

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

- Hyperemesis gravidarum (pernicious vomiting of pregnancy); toxemia with convulsions; severe bleeding before delivery due to premature separation of the placenta from any cause; bleeding after delivery severe enough to need a transfusion or blood
- Amniotic fluid tests, analyses, or intra-uterine fetal transfusion made for Rh incompatibility
- An emergency medical cesarean section due to pregnancy complications
- Miscarriage if not elective or therapeutic

Pregnancy complications do not include a scheduled or non-emergency cesarean delivery.

### Important note:

You should review the benefit under *Eligible health services* under your plan-*Maternity and related newborn care* and the *exceptions* sections of this booklet-certificate for more information on coverage for pregnancy expenses under this plan.

## Jaw joint disorder treatment

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

Jaw joint disorder treatment	
Jaw joint disorder treatment	0% (of the <b>negotiated charge</b> ) per visit
	No <b>deductible</b> applies

## Mental health treatment

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

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital** or

**residential treatment facility**, including:

- **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**.
- **Intensive Outpatient Program** provided in a facility or program for mental health treatment provided under the direction of a **physician**.
- Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor.

**Important note:**

Please refer to the *Physicians and other health professionals* section for information about **eligible health services** for **e-visits** and **telemedicine** consultations.

## Ambulance service

**Eligible health services** include transport by professional ground **ambulance** services:

- To the first **hospital** to provide **emergency services**.
- From one **hospital** to another **hospital** if the first **hospital** cannot provide the **emergency services** you need.
- From **hospital** to your home or to another facility if an **ambulance** is the only safe way to transport you.
- For your newborn child and disabled mother to a hospital or neonatal unit.
- From your home to a **hospital** if an **ambulance** is the only safe way to transport you. Transport is limited to 100 miles.

Your plan also covers transportation to a **hospital** by professional air or water **ambulance** when:

- Professional ground **ambulance** transportation is not available.
- Your condition is unstable, and requires medical supervision and rapid transport.
- You are travelling from one **hospital** to another and
  - The first **hospital** cannot provide the **emergency medical services** you need, and
  - The two conditions above are met.

For purposes of this benefit:

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

## Clinical trial therapies (experimental or investigational)

**Eligible health services** include **experimental or investigational** drugs, devices, early detection, prevention, treatments or procedures from a **provider** under an “approved clinical trial” only when you have cancer or other life-threatening disease or condition.

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

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

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an institutional review board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.

- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

### **Clinical trials (routine patient costs)**

**Eligible health services** include "routine patient costs" incurred by you from a **provider** in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

Costs of investigational treatments and costs of associated protocol-related patient care shall be covered if all of the following criteria are met:

1. The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention of early detection of cancer
2. The treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV, clinical trial for cancer
3. The treatment is being provided in accordance with an approved clinical trial must satisfy one of the following:
  - Federally funded trials:
    - The study or investigation is approved or funded by one or more of the following:
      - The National Institutes of Health
      - The Centers for Disease Control and Prevention
      - The Agency for Health Care Research and Quality
      - The Centers for Medicare & Medicaid Services
      - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
      - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
      - The Department of Veterans Affairs
      - The Department of Defense
      - The Department of Energy
    - For those approved by the Departments of Veterans Affairs, Defense or Energy, the study or investigation must have been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines:
      - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health
      - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
  - The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
  - The study or investigation is a drug trial that is exempt from having such an investigational new drug application

### **COVID-19 services**

**Covered services** include the following when ordered by a **physician**:

- Diagnostic test
- Antibody tests that:
  - Are fully approved or granted Emergency Use Authorization by the FDA.



- Follow the Enzymes-Linked Immunosorbent Assay (ELIA) test mythology performed in highly complex clinical laboratories and includes an antibody titer infection
- Anti-viral drugs fully approved or granted Emergency Use Authorization by the FDA for the treatment or prevention of COVID-19

The following are not **covered services** when used for employment, employment-related or public health surveillance purposes:

- Diagnostic test
- Antibody test

<b>Hearing aids and exams for minors</b>	
Hearing aid exams	Covered according to the type of benefit and the place where the service is received.
Covered person through age 25	No <b>deductible</b> applies.
Hearing aids	Covered according to the type of benefit and the place where the service is received.
Covered person through age 25	No <b>deductible</b> applies.
Hearing aids	One per ear every 36 month consecutive period.

## Nutritional supplements

**Eligible health services** include treatment for 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.

<b>Nutritional supplements</b>	
Nutritional supplements	Covered according to the type of benefit and the place where the service is received

## Osteoporosis

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

- Estrogen-deficient woman at clinical risk of osteoporosis who is considering treatment
- Individual receiving long-term steroid therapy
- Individual receiving approved osteoporosis drug therapies

<b>Osteoporosis</b>	
<b>Physician's</b> office visits	Covered according to the type of benefit and the place where the service is received

## Prosthetic devices and services

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

Prosthetic device means:

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

Coverage includes:

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

Prosthetic devices and services	
Prosthetic devices and services	Covered according to the type of benefit and the place where the service is received.

## Reconstructive breast surgery and supplies

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

- All stages of reconstruction of the breast on which a unilateral mastectomy has been performed and on the other breast to produce a symmetrical appearance including:
  - Contralateral prophylactic mastectomies
  - Liposuction performed for transfer to a reconstructed breast or repair donor site deformity
  - Tattooing the areola of the breast
  - Surgical adjustments of the of the non-mastectomized breast
  - Unforeseen medical complications which may require additional reconstruction in the future
  - Prostheses and physical complications
  - Lymphedema
- All stages of reconstruction of both breasts if a bilateral mastectomy has been performed including:
  - Liposuction performed for transfer to a reconstructed breast or repair donor site deformity
  - Tattooing the areola of the breast
  - Unforeseen medical complications which may require additional reconstruction in the future
  - Prostheses and physical complications
  - Lymphedema
- Breast reconstruction procedures to be performed shall be made solely by the patient in consultation with attending **physicians** regardless of whether a partial mastectomy or a full unilateral or bilateral mastectomy is chosen by the patient and **physician**
- Preventive cancer screenings, on no less than an annual basis, for an insured or enrollee who:
  - Was previously diagnosed with breast cancer
  - Completed treatment for breast cancer
  - Underwent a bilateral mastectomy
  - Was subsequently determined to be clear of cancer

Certain **prescription** drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following **precertification** information applies to these **prescription** drugs:

## Step therapy

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

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

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

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

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

## Requesting a medical exception

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

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

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

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

If you are denied a medical exception based on the above processes, you may have the right to a third party review by an independent review organization. If our claim decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external review process. We will tell you, or someone who represents you or your **prescriber** of the

coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the **prescription**. For quicker medical exceptions in urgent situations, we will tell you, or someone who represents you or your **prescriber** of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation.

## Telemedicine

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

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

The following are not **covered services**:

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

## Translation charges

**Eligible health services** include translation charges for a qualified interpreter/translator. We cover these charges in connection with your medical treatment performed by a **physician**. This is available to you if the services are required because you have a hearing impairment or you cannot understand or communicate in spoken language.

The interpreter/translator cannot be a family member.

Translation charges	
Translation charges	Covered according to the type of benefit and the place where the service is received.

## Treatment of metastatic or unresectable tumors

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

### Important note

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

## Retail pharmacy

Generally, **retail pharmacies** may be used for up to a 30 day supply of **prescription drugs**. You should show your ID card to the **network pharmacy** every time you get a **prescription** filled. The **network pharmacy** will calculate your claim online. You will pay any cost sharing directly to the **network pharmacy**.

You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

See the schedule of benefits for details on supply limits and cost sharing.

### Mail order pharmacy

For certain kinds of **prescription drugs**, you can use the plan’s **network 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.

Outpatient **prescription drugs** are covered when dispensed by a **network 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 **network mail order pharmacy**.

### 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.

The dollar limits, **copayments**, **deductibles**, or **coinsurance** requirements for covered orally administered anti-cancer drugs will be no less favorable to you than the dollar limits, copayments, deductibles, or coinsurance requirements that apply to covered anti-cancer drugs that are administered intravenously or by injection. (This provision does not apply to High Deductible Health Plans)

### 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.

	<b>If you are a new enrollee and your provider is an out-of-network provider</b>	<b>When your provider stops participation with Aetna</b>
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 <b>provider</b> should call <b>us</b> 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 <b>provider</b> terminated their participation with <b>us</b> .

If you are pregnant and have entered your second trimester, or are diagnosed to have a high-risk pregnancy, 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**.

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

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

### When you are injured

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

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

- You are agreeing to repay us from money you receive because of your **injury**.
- You are giving us a right to seek money in your name, from any person who causes you **injury** and from your own insurance. We can seek money only up to the amount we paid for your care. You are agreeing to cooperate with us so we can get paid back. For example, you’ll tell us if you seek money for your **injury** or **illness**. You’ll hold any money you receive until we are paid. And you’ll give us the right to money you get, ahead of everyone else.

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

## When you disagree - claim decisions and appeals procedures

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

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

### Claim procedures

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none"> <li>• You should notify and request a claim form from your employer.</li> <li>• The claim form will provide instructions on how to complete and where to send the form(s).</li> </ul>	<ul style="list-style-type: none"> <li>• You must send us notice and proof as soon as reasonably possible.</li> <li>• If you are unable to complete a claim form, you may send us:               <ul style="list-style-type: none"> <li>– A description of services</li> <li>– Bill of charges</li> <li>– Any medical documentation you received from your <b>provider</b></li> </ul> </li> </ul>
Proof of loss (claim)	<ul style="list-style-type: none"> <li>• A completed claim form and any additional information required by</li> </ul>	<ul style="list-style-type: none"> <li>• You must send us notice and proof as soon as reasonably possible.</li> </ul>

	us.	
Benefit payment	<ul style="list-style-type: none"> <li>• Written proof must be provided for all benefits.</li> <li>• If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.</li> </ul>	<ul style="list-style-type: none"> <li>• Benefits will be paid as soon as the necessary proof to support the claim is received.</li> </ul>

## Types of claims and communicating our claim decisions

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

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

### Urgent care claim

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

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

### Pre-service claim

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

### Post-service claim

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

### Concurrent care claim extension

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

### Concurrent care claim reduction or termination

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

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

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

We may need to tell your **physician** about our decision on some types of claims, such as a concurrent care claim,

or a claim when you are already receiving the health care services or are in the **hospital**.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	72 hours	2 days	30 days	As soon as possible but not later than 24 hours for urgent request*, or 72 hours if clinical information is required and received more than 24 hours after request  15 calendar days for non-urgent request
Extensions	None	15 days from the date of the pre-service claim request	15 days from the date of the post-service claim request	Not applicable
Additional information request (us)	As soon as possible but not more than 24 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

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

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

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



- Rescission

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

### **Authorized representative**

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

### **Grievance**

A grievance is a type of complaint that involves an urgent care request. You or your provider can call the toll-free number on the back of your ID card or write Member Services at P.O. Box 14462 Lexington, KY 40512 to let us know about your grievance. This can include a complaint about:

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

### **The difference between a complaint and an appeal**

#### **A complaint**

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

#### **An appeal**

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

### **Appeals of adverse benefit determinations**

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

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

- Your name
- Your employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal

- Any other information you would like us to consider

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

You can appeal two times under this plan. We call these levels a level 1 or level 2 appeal. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

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

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

You may also call the toll-free number 1-800-259-5300 or visit the LDI web site at [www.lidi.la.gov](http://www.lidi.la.gov).

### Urgent care or pre-service claim appeals

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

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

### Timeframes for deciding appeals

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	Levels 1 and 2 written decision 36 hours  3 days oral decision	Level 1 –written decision 15 days  Level 2 – written decision 5 days	30 days  Level 2 – written decision 5 days	As soon as possible but not later than 24hours for urgent request
Extensions	None	None	None	

## Exhaustion of appeals process

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

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

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

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

## External review

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

The types of External reviews are:

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

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

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

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

You may make an oral or written request for an external review:

### To **Aetna**

At the time that you receive the decision from **Aetna** of an adverse determination or final adverse determination, when you are requesting an expedited external review

Within 4 months of the date you received the notice of the decision from **Aetna** of an adverse determination or final adverse determination, when you are requesting a standard external review or a standard or expedited external review for experimental or investigational treatment

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

Upon request and free of charge, we will provide you with copies of all documents about your claim. You will

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

**Aetna will:**

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

The IRO will:

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

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

**How long will it take to get an IRO decision?**

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

But sometimes you can get a faster external review decision. You or your authorized representative must call us or send us a request for external review form.

There are scenarios when you may be able to get an expedited external review:

**For initial adverse determinations**

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

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

**For final adverse determinations**

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

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

**Timeframes for external review decisions**

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

Type of external review	When we complete a preliminary review of the request and notify you	When the review request is assigned to the IRO	When the IRO completes their review and notifies you
<b>Standard external</b>	Within 5 business	Within 1 business	Within 45 days after

<b>review</b>	days	day after receiving request from <b>Aetna</b>	the date of receipt of the request
<b>Expedited external review (oral or written)</b>	Immediately after receiving request	Immediately after receiving request from <b>Aetna</b>	As soon as possible but no longer than 72 hours after getting assigned
<b>Standard external review of experimental or investigational treatment adverse determinations</b>	<ul style="list-style-type: none"> <li>• Within 5 business days after receiving request to determine eligibility</li> </ul>	Within 1 business day after the date of receiving request from <b>Aetna</b>	Within 20 days after the date it receives the opinion of each clinical peer to make a decision (clinical peers have 20 days to provide a written opinion to IRO)
<b>Expedited external review of experimental or investigational treatment adverse determinations</b>	Immediately after receiving request	Immediately after receiving request from <b>Aetna</b>	<ul style="list-style-type: none"> <li>• As soon as possible but no longer than 8 days after receipt of assignment</li> </ul> <p>The decision may take up to 8 days because the:</p> <ul style="list-style-type: none"> <li>- IRO has 1 day after receiving the request to assign the review to clinical peers</li> <li>- Clinical peers shall provide an oral or written opinion to the IRO as soon as possible but no longer than 5 days of being assigned</li> </ul> <ul style="list-style-type: none"> <li>• IRO has 48 hours after the date it receives the opinion of each clinical peer to make a decision</li> </ul>

## **Recordkeeping**

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

## **Fees and expenses**

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal. We will pay for fees or expenses incurred by us for sending information to the IRO and the cost of the external review.

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

A handwritten signature in black ink, appearing to read 'Dan Finke', with a long horizontal stroke extending to the right.

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

Amendment: Louisiana ET Rider  
Issue Date: February 2, 2022

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

**Important note:** The following apply only if you live in Massachusetts. The benefits below will apply instead of those in your booklet-certificate.

### Interpreter and translation services

TTY: 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)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862. (Portuguese)

如欲使用免費語言服務，請致電 1-888-982-3862。 (Chinese)

Pou jwenn sèvis lang gratis, rele 1-888-982-3862. (French Creole-Haitian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862. (Vietnamese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862. (Russian)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862. (Arabic)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862។ (Mon-Khmer, Cambodian)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862. (French)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862 . (Italian)

무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. (Korean)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862. (Greek)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonąć 1-888-982-3862 (Polish)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-982-3862 पर कॉल करें। (Hindi)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-888-982-3862. (Gujarati)

## Physician profiling

Physician profiling information is available from the Massachusetts Board of Registration in Medicine for **physicians** licensed to practice in Massachusetts.

## Maximum coinsurance differential for network plans

In no event will the covered amount for In-Network charges exceed more than 20% of the covered amount for Out-of-Network charges.

## How do you extend coverage if you leave your job

If your employment ends because you leave your job, you may continue benefits for you and your dependents for 31 days. You must ask that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Benefits will end before the end of the 31 days on the first of:

- The date you are eligible for benefits under another group plan
- The date you fail to make any premium contribution needed

## How do you extend coverage if your plant closes

If your employment ends due to a plant closing or partial closing, you may continue benefits (except dental coverage) for you and your dependents for 90 days. You must ask that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Benefits will end before the end of the 90 days on the first of:

- The date you are eligible for benefits under another group plan
- The date you fail to make any contribution needed

## How do you extend coverage for a former spouse



If you get divorced or separated from your spouse, your former spouse may continue to be covered unless a court judgment or divorce decree specifies otherwise, the same dependent premium and contribution rates will apply.

Benefits will end on the earliest of:

- The date specified in a judgment or decree
- The date your former spouse remarries
- The date you remarry
- The date you are no longer covered by the policy

In the event you remarry, your former spouse has the right, if so provided in the judgment, to continue to receive coverage under this agreement. If the judgment provides for this continuation of benefits, your former spouse may continue coverage under the group plan until the date specified in the judgment, the date your former spouse remarries or the date that you are no longer covered by the policy

Notice of cancellation of coverage of your divorced or separated spouse will be mailed to the divorced or separated spouse at their last known address together with notice of the right to reinstate coverage retroactively to the date of cancellation.

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: Massachusetts Medical ET  
Issue Date: February 2, 2022

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

**Important note:** The following apply only if you live in Maine. The benefits below will apply instead of those in your booklet-certificate.

### Children's early intervention services

Covered services include children's early intervention services for dependents from birth to 36 months with an identified development disability or delay, as described in the Federal Individual with Education Act, Part C, United States Code, Section 1411, et seq. These services may be provided by:

- Licensed occupational therapists
- Physical therapists
- Speech-language pathologists, or
- Clinical social workers
- Other providers as designated within the Disabilities Act

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

**Covered services** include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training, including training and education services provided through ambulatory diabetes facilities authorized by the State's Diabetes Control Project within the Bureau of Health

## Elective Abortion

Unless coverage is provided under a policy issued in the state of Missouri, or a religious affiliated employer has elected not to provide, covered services also include the services and supplies provided for the voluntary termination of a pregnancy performed by a health professional.

## Hearing aids

Hearing aid means:

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

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

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

The following are not **covered services**:

- Replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within a 36 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

## Hospice care

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

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

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a **hospital**
- Psychological and dietary counseling
- Pain management and symptom control
- Bereavement counseling
- Respite care

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

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

- Psychological counseling
- Dietary counseling

The following are not **covered services**:

- Funeral arrangements
- Financial or legal counseling including estate planning and the drafting of a will
- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
  - Sitter or companion services for you or other family members
  - Transportation
  - Maintenance of the house

## **Nutritional support**

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

**Covered services** include parenteral and enteral 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.

Covered services also include amino based elemental infant formula for any of the following documented conditions in children 2 and under:

- Symptomatic allergic colitis and proctitis
- Laboratory or biopsy proven allergic or eosinophilic gastroenteritis
- History of anaphylaxis
- Gastresophageal reflux disease
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a **provider**
- Cystic fibrosis
- Malabsorption of cow-milk based or soy-milk based infant formula

The submitted documentation for the above mentioned conditions must show:

- The formula is medically necessary as defined by Maine law
- The formula is 50% or more the primary nutrition source

Other commercial infant formulas, including cow and soy milks, have been tried, failed or are contraindicated.

The following are not **covered services**:

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

## **Routine Cancer Screenings**

Mammograms under the Routine Cancer Screening benefit also include an additional radiologic procedure recommended by a **provider** when the results of an initial radiologic procedure are not definitive.

## Prosthetic device

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

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

Coverage includes:

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

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

The following are not **covered services**:

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

### You might not have to pay a “surprise bill”

In cases where you try to stay in the network for your **covered services**, you may get a bill you didn’t expect. The plan may have approved coverage but you went outside the network without even knowing it.

When you’re a patient in a **hospital**, the **hospital** may be in the network but some services you receive can be from doctors and labs who are not in the network. You can tell the **hospital** staff to only use network services during your stay, but that’s not always possible. When you have no choice, you should only have to pay the same amount as when you do stay in the network. Contact us if you receive any surprise bills.

It is not a surprise bill when you knowingly choose to go outside the network. In this case, you will have to pay for it.

## Requesting a medical exception

Sometimes you or your **provider** may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. We will process your request through our standard medical exception process within 72 hours or 2 business days, whichever is less, after receipt. If approved, you may receive the non-preferred drug benefit level and the exception will apply for the entire time you are taking the prescription. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

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

your prescriber may submit a request for a quicker review for an urgent situation by:

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

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your provider of our decision.

### **Continuity of prescription drugs**

If you are undergoing a course of treatment with a previously authorized **prescription** drug from another carrier and your coverage is replaced by this coverage, we will honor the prior carrier's authorization. We will continue to provide coverage in the same manner until we review the authorization with your prescriber.

### **Why would we end your coverage?**

We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage.

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

### **Reinstatement due to cognitive impairment or functional incapacity**

You may tell us if you would like a representative appointed or changed for notifications. If we discontinue coverage for failure to pay your premium, you or your representative, will receive the notification for termination 10 days before the termination date. You or your representative may submit a request for reinstatement within 90 days of the notice, showing that your failure to pay was due to native impairment or functional incapacity.

We may request medical documentation, at your expense, documenting the diminished capacity.

### **How you can extend coverage if your coverage ends because you are laid-off or you sustain an injury or disease compensable under Workers' Compensation**

If you are totally disabled when coverage ends, coverage for you and your dependents may be extended if your coverage ended because:

- You are temporarily laid-off
- You are permanently laid-off and are eligible for premium assistance pursuant to federal law; or
- You sustain an injury or disease that you claim to be compensable under Workers' Compensation law.

You are eligible to extend your coverage under this provision if:

- You had group health coverage continuously under this plan for the last 6 consecutive months

Your dependents are eligible to extend coverage under this provision if:

- They had group coverage continuously under this plan for the last 3 consecutive months, unless they were not eligible for coverage until after the beginning of that 3 month period

You may extend coverage until the earliest of:

- When you become covered by another health benefits plan
- 12 months from the date of last employment

- The date the Workers' Compensation Board determines that the injury or disease that entitles you to continue coverage under this provision is not compensable under applicable Workers' Compensation law
- You fail to pay any required extension premium

We will extend your coverage only if you pay extension premiums. You must pay your first extension premium within 31 days after your coverage ends. Your extension premium may be up to 102% of the premium charged to a member whose coverage has not ended.

## Provider

A provider under your plan is defined as a **physician, health professional**, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare.

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: Maine Medical ET

Issue Date: February 2, 2022

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

**Important note:** The following apply only if you live in Minnesota. The benefits below will apply instead of those in your booklet-certificate.

### 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
- Your dependent children – your own or those of your spouse or domestic partner
  - The children must be under 26 years of age, and they include your:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
    - Grandchildren in your court-ordered custody
    - Any other child with whom you have a parent-child relationship

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.



## Routine cancer screenings

**Eligible health services** include the following routine cancer screenings:

- Mammograms
- Ovarian cancer surveillance tests for women who are at risk for ovarian cancer
- Prostate specific antigen (PSA) blood tests and digital rectal exams for men:
  - 40 years of age or over who are symptomatic or in a high-risk category
  - 50 years of age or older
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

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

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

## Children's health supervision

**Eligible health services** include child health supervision services.

As appropriate for a child from birth to age 6, child health supervision services include:

- Pediatric preventive services
- Immunizations
- Developmental assessments
- Laboratory services

The child health supervision visit frequency and age ranges are as follows:

- Birth to 12 months: At least 5 visits
- 12-24 months: 3 visits
- 24-72 months: 1 per year

As appropriate for a child from age 6 to 18, **eligible health services** include immunizations as defined by the Standards of Child Health Care as issued by the American Academy of Pediatrics.

## Hospital and other facility care

### Hospital care

**Eligible health services** include inpatient and outpatient **hospital** care.

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

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- If you are severely disabled, have a medical condition, or are a dependent child under the age of 5,

anesthesia and hospital charges for dental care treatment that requires hospitalization or general anesthesia

- Services of **physicians** employed by the **hospital**
- Operating and recovery rooms
- Intensive or special care units of a **hospital**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product
- Radiation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a **hospital**.
- **Hospital** and anesthesia charges if you are either:
  - A dependent child under age 5
  - Severely disabled
  - Have a medical condition that requires hospitalization or general anesthesia for dental care

## Home health care

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

- You are homebound.
- Your **physician** orders them.
- The services take the place of your needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home.
- The services are a part of a **home health care plan**.
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.
- If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.
- Home health aide services are provided under the supervision of a registered nurse.
- Medical social services are provided by or supervised by a **physician** or social worker.

If you are ventilator-dependent, **eligible health expenses** include 120 hours of services by a home care nurse or personal care assistant during the time you are in a **hospital**. The personal care assistant or home care nurse will serve as your communicator or interpreter to assure adequate training of the **hospital** staff to communicate with you and to understand your unique comfort, safety and personal care needs.

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

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

## Autism spectrum disorder

Autism Spectrum Disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of*

*Mental Disorders* (DSM) of the American Psychiatric Association.

**Eligible health services** include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of Autism Spectrum Disorder.

We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.

We will cover early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That is responsible for observable improvements in behavior.

For a covered dependent child under age 18, eligible health services also include an evaluation and multidisciplinary assessment. The diagnosis, evaluation and assessment includes an assessment of the child's:

- Developmental skills
- Functional behavior
- Needs
- Capacities

Treatment also includes, but is not limited to:

- Early intensive behavioral and developmental therapy based in behavioral and developmental science. This includes, but is not limited to:
  - All types of applied behavior analysis
  - Intensive early intervention behavior therapy
  - Intensive behavior intervention;
- Neurodevelopmental and behavioral health treatments and management
- Speech therapy
- Occupational therapy
- Physical therapy
- Medications.

We may request an updated treatment plan only once every 6 months, unless the treating physician or behavioral health provider agrees that a more frequent review is necessary due to emerging circumstances.

An independent progress evaluation conducted by a behavioral health provider, with expertise and training in autism spectrum disorder and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made.

**Important note:**

Applied behavior analysis requires **precertification** by **Aetna**. The **network provider** is responsible for obtaining **precertification**. You are responsible for obtaining **precertification** if you are using an **out-of-network provider**.

### **Cleft lip and cleft palate for a covered dependent child under age 19**

**Eligible health services** include inpatient or outpatient medical and dental treatment for a covered dependent. This includes orthodontic and oral **surgery** for the management of birth defects known as cleft lip and cleft

palate.

For covered dependents age 19 up to the limiting age, **eligible health services** are limited to treatment that was scheduled or initiated prior to the dependent turning age 19.

Under this provision, if orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan is primary and the other policy or contract is secondary.

### **Clinical trial therapies (experimental or investigational)**

**Eligible health services** include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial".

An "approved clinical trial" is a phase I, phase II, phase III or phase IV clinical trial that is conducted for the prevention, detection or treatment of cancer or a life-threatening condition and is not designed exclusively to test toxicity or disease pathophysiology and must be:

- Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration (FDA).
- Exempt from obtaining an investigational new drug application
- Approved or funded by:
  - The National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services or a cooperating group or center for any of these entities.
  - A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs
  - A qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants
  - The United States Department of Veteran Affairs, Defense or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to:
    - Be comparable to the system of peer review of studies and investigations used by the NIH
    - Provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review

### **Clinical trials (routine patient costs)**

**Eligible health services** include "routine patient costs" incurred by you from a **provider** in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition.

A "qualified individual" means an individual with health plan coverage who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or a life-threatening condition because:

- The referring health care professional is participating in the trial and has concluded that your participation in the trial would be appropriate
- You provided medical and scientific information establishing that your participation in the trial is appropriate because you meet the conditions described in the trial protocol

As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network.

### **Diabetic equipment, supplies and education**

**Eligible health services** include:

- Equipment, services and supplies used in the management and treatment of diabetes
- Training and education
  - Self-management training and education (including medical nutritional therapy) provided by a health care **provider** working in a program consistent with the national standard of diabetes self-management education, as established by the American Diabetes Association

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

## **Jaw joint disorder treatment**

**Eligible health services** include the diagnosis and surgical and non-surgical treatment of **jaw joint disorder** when administered or prescribed by a **physician** or **dental provider** which includes:

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

## **Lyme disease**

**Eligible health services** include treatment of Lyme disease.

## **Pediatric streptococcal related conditions**

**Eligible health services** include services related to the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS), including behavioral therapies to manage neuropsychiatric symptoms, plasma exchange and immunoglobulin.

## **Port-wine stains**

**Eligible health services** include the elimination or maximum feasible treatment of port-wine stains.

## **Mental health treatment**

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

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital or residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation).
  - Individual, group and family therapies for the treatment of mental health
  - Other outpatient mental health treatment such as:
    - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following

criteria are met:

- You are homebound
  - You **physician** orders them
  - The services take the place of a stay in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
- Electro-convulsive therapy (ECT)
  - Transcranial magnetic stimulation (TMS)
  - Psychological testing
  - Neuropsychological testing
  - 23-hour observation
  - Peer counseling support by a peer support **specialist**
    - A peer support **specialist** serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.
- **Residential treatment facility**, licensed by the Commissioner of Human Services, for the treatment of emotionally disabled children. “Emotionally disabled child” has the meaning set forth by the Commissioner of Human Services in the rules relating to **residential treatment facilities**.
  - Court-ordered **mental disorders** services to treat or improve an emotional, behavioral or psychiatric condition, otherwise covered under this **group policy**. The court order must be issued based on a behavioral care evaluation performed by a licensed **psychiatrist** or a doctoral level licensed psychologist. The court order and behavioral care evaluation must:
    - Be provided to **Aetna**
    - Include a diagnosis and an individual treatment plan for care in the most appropriate and least restrictive environment.

**Eligible health services** include the:

- Evaluation if performed by a **network provider**
- Care included in the court-ordered individual treatment plan if the care is
  - A **covered benefit** under the plan
  - Ordered to be provided by a **network provider** or another **provider** as required by law.

**We** will not subject the court-ordered treatment to a separate **medical necessity** determination.

A party or interested person, including **Aetna** or its designee, may move to modify the court-ordered plan of care pursuant to the applicable rules of procedure for modification of a court order. The motion may include a request for a new behavioral care evaluation.

## **Reconstructive surgery 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** reconstructs the breast where a **medically necessary** (as determined in consultation between you and your **physician**) mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses.
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:

- The defect results in severe facial disfigurement or major functional impairment of a body part.
- The purpose of the **surgery** is to improve function.
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.
- Your **surgery** when incidental to or follows a **surgery** resulting from **injury, illness** or other diseases of the involved part.
- Your covered dependent child's **surgery** due to a congenital disease or anomaly which resulted in a functional defect, as determined by their **physician**.

## Durable medical equipment (DME)

**Eligible health services** include the expense of renting or buying **DME** and accessories you need to operate the item from a **DME** supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

Your plan only covers the same type of **DME** that Medicare covers. But there are some **DME** items Medicare covers that your plan does not. We list examples of those in the *exceptions* section.

For more information pertaining to **DME**, call the toll-free Member Services number on your member ID card or log on to your secure member website at [www.aetna.com](http://www.aetna.com).

## Hearing aids and exams for a covered person age 18 and under

**Eligible health services** include hearing care that includes hearing exams, prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

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

Hearing aid services are:

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

For individuals 18 years of age or younger:

- **Eligible health services** include hearing aids for hearing loss that is not correctable by other covered procedures.
- Hearing aids are limited to 1 hearing aid in each ear every 3 years.
- No special deductible, coinsurance, copayment or other limitation on the coverage, that is not generally applicable to other coverages under the plan, will be imposed.

## 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.

## Prosthetic devices

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

Prosthetic device means:

- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of **illness** or **injury** or congenital defects.
- Scalp hair prostheses worn for hair loss suffered as a result of alopecia areata. Scalp hair prostheses are limited to 1 per calendar year.

Coverage includes:

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

## Non-preferred drug guide antipsychotic prescription drugs

Regardless of whether the drug is in the **preferred drug guide**, **eligible health services** include antipsychotic **prescription drugs** prescribed to treat an emotional disturbance or **mental disorders** if the **prescriber**:

- Indicates to the **pharmacy**, verbally or in writing, that the **prescription** must be dispensed as communicated
- Certifies in writing to **Aetna** that the prescribing **provider** considered all equivalent drugs in the **drug guide** and determined that the drug prescribed will best treat your condition

We will not provide coverage for a drug if the drug was removed from the **preferred drug guide** for safety reasons.

For **prescription drugs** covered under this section, for which certification was received, we will not:

- Impose a special **deductible**, **copayment** or **coinsurance** not applied to **prescription drugs** that are in the **preferred drug guide**
- Require written certification each time the **prescription** is refilled or renewed

In addition, if the **prescription drug** used to treat the **mental disorder** or emotional disturbance has shown to effectively treat your condition, you may continue to receive the **prescription drug** for up to 1 year without the imposition of special payment requirements when:



- The **preferred drug guide** changes
- You change health plans

In order to be eligible for continuity of care:

- You must have been treated with the **prescription drug** for 90 days prior to the change
- Your **prescriber** must:
  - Indicate to the **pharmacy**, verbally or in writing that the **prescription** must be dispensed as communicated
  - Certify in writing to **Aetna** that the **prescription drug** will best treat your condition

The continuing care benefit will be extended annually when:

- The **prescriber** re-indicates dispensed as communicate
- Renews the certification with **Aetna**.

We will grant a medical exception to the **preferred drug guide** when the **prescriber** indicates that the:

- **Preferred drug guide prescription drug**
  - Caused an adverse reaction
  - Is contradicted for you
- **Prescription drug** must be Dispensed As Written (DAW) to provide maximum medical benefits to you.

The following is added to the *Diabetic supplies, drugs and insulin* provision within the *Eligible health services-Outpatient prescription drugs* section of your schedule of benefits:

Important Note: The total amount of cost-sharing that you are required to pay, including any **deductible** and **copayment**, will not exceed the net price of the prescription insulin drug.

## 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 **precertification** 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 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.

A **step therapy** medical exception, for a **prescription drug** covered under your plan, will be granted if one of the following conditions exist:

- The **prescription drug** required under **step therapy** is contraindicated based on the manufacturer's prescribing information for the drug

- Due to a documented adverse event with prior use or a documented medical condition, the **prescription drug** required under **step therapy** is likely to do any of the following:
  - Cause you an adverse reaction
  - Decrease your ability to achieve or maintain reasonable functional ability in *performing* daily activities
  - Cause you physical or mental harm
- You took the required **prescription drug** during a sufficient trial and the **prescription drug** was discontinued by your **prescriber** due to lack of effectiveness or an adverse event
- You are currently receiving a positive therapeutic outcome on a **prescription drug** for your medical condition, it is one for which you received **covered benefits** and your **prescriber** provides documentation that a change in the **prescription drug** required by **step therapy** is expected to be ineffective or cause harm
- You are receiving treatment for stage four advanced metastatic cancer or associated conditions

To request a **step therapy** medical exception:

- You or your **prescriber** can call the toll-free number on your member ID card.
- You can log into your secure member website at [www.aetna.com](http://www.aetna.com) and submit a request through the Contact Us feature
- You or your **prescriber** can fill out a **step therapy** request form. To obtain this form, go to <https://www.aetna.com/faqs-health-insurance/pharmacy-faqs.html>. See **step therapy** and click the plus sign.
  - Fax, the fax number is on the form
  - Through our secure **provider** website, Navnet. Only your **prescriber** can use this option.
  - By mail. The mailing address is:  
**Aetna Pharmacy Management**  
 1300 East Campbell Road  
 Richardson, TX 75001

### **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.

	<b>If you are a new enrollee and your provider is an out-of-network provider</b>	<b>When your provider stops participation with Aetna</b>
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 <b>provider</b> should call <b>us</b> for approval to continue any care.
Length of transitional period	Care will continue during a transitional, for up to 120 days.	Care will continue during a transitional period for up to 120 days. This date is based on the date the <b>provider</b> terminated their participation with <b>us</b> .

	<b>If you are a new enrollee and your provider is not contracted with Aetna</b>
Request for approval	You need to complete a Transition of Coverage Request form and send it to us. You can get this form by calling the toll-free number on your ID card.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.
How claim is paid	Your claim will be paid at the <b>network provider</b> cost sharing level.

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**.

### **Important note--unauthorized provider services-surprise billing**

A surprise bill is a bill you receive for **eligible health services** performed by:

- An **out-of-network provider** at a **network facility** when:
  - A **network provider** is unavailable at the time the **eligible health services** are performed
  - An **out-of-network provider** performs services without your knowledge
  - Unforeseen medical issues or services arise at the time the **eligible health services** are performed
- A **network provider** sends a specimen to an **out-of-network** laboratory, pathologist or other medical testing facility

A surprise bill does not include a bill for **emergency services**.

In the case of a surprise bill, you will pay the same cost share you would if the **eligible health services** were received from a **network provider** (the **in-network** cost share). In other words, any cost share you pay related to the surprise bill will count toward your **in-network**

- **Deductible**, if any
- **Copayments/coinsurance**
- Coverage restrictions or limitations, if any
- **Maximum out-of-pocket limit**

An **out-of-network provider** can bill you the **out-of-network** cost sharing only when they get your advance written consent.

When a surprise bill is received, **Aetna** will attempt to negotiate reimbursement with the **out-of-network provider**. If the attempts to negotiate fail, **Aetna** or the **provider** may seek binding arbitration. The cost of arbitration will be shared equally between the parties.

## Claim procedures

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none"> <li>You should notify and request a claim form from the policyholder.</li> <li>The claim form will provide instructions on how to complete and where to send the form(s).</li> </ul>	<ul style="list-style-type: none"> <li>You must send us notice and proof as soon as reasonably possible.</li> <li>If you are unable to complete a claim form, you may send us: <ul style="list-style-type: none"> <li>A description of services</li> <li>Bill of charges</li> </ul> </li> <li>Any medical documentation you received from your <b>provider</b></li> </ul>
Proof of loss (claim)	<ul style="list-style-type: none"> <li>A completed claim form and any additional information required by us.</li> </ul>	<ul style="list-style-type: none"> <li>You must send us notice and proof as soon as reasonably possible</li> </ul>
Benefit payment	<ul style="list-style-type: none"> <li>Written proof must be provided for all benefits.</li> <li>If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.</li> </ul>	<ul style="list-style-type: none"> <li>Benefits will be paid as soon as the necessary proof to support the claim is received.</li> </ul>

## Types of claims and communicating our claim decisions

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

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

### Urgent care claim

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

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

### Pre-service claim

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

### Post-service claim

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

### Concurrent care claim extension

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

### Concurrent care claim reduction or termination

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

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

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	72 hours	15 days	30 days	24 hours for urgent request*  15 calendar days for non-urgent request
Extensions	None	14 days	15 days	Not applicable

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

### 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 in “Why we would end your coverage”).

Your coverage will end on either the last day of the month in which 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 month of the period defined by the policyholder following the date on which you no longer meet the

eligibility requirements.

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

Your coverage may be extended if you or your dependents are totally disabled when coverage ends.

You are “totally disabled” if you cannot work at your own occupation within the first two years of your disability or you cannot work at your own occupation or any other occupation for pay or profit after two years of your disability.

Your dependent is “totally disabled” if that person cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage until the earliest of:

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

### **How can you extend coverage for a dependent after you die?**

Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 90 days after your death, and
- Payment is made for the coverage

Your dependent’s coverage will end on the earliest date:

- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions stop, or
- The date your spouse remarries

To request extension of coverage the dependent or their representative can just call the toll-free Member Services number on the ID card. Your dependent may pay up to 102% of the total plan cost.

### **How you can extend coverage after you are voluntarily or involuntarily terminated or laid off from employment?**

You and your dependents can continue coverage after you are voluntarily or involuntarily terminated or laid off from employment, except for gross misconduct, if:

- The request is made within 60 days after you are voluntarily or involuntarily terminated or laid off from employment
- Payment is made for the coverage.

You and your dependent's coverage will end on the earliest date:

- The end of the 18th month period after the date you are voluntarily or involuntarily terminated or laid off from employment
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- You or your dependent becomes covered by another health benefits plan
- Any required contributions stop, or
- The date your spouse remarries

To request extension of coverage you can just call the toll-free Member Services number on your ID card. Your dependents may pay up to 102% of the total plan costs.

**How can you extend coverage for a dependent after divorce and are no longer responsible for dependent coverage?**

Your dependents can continue coverage after you divorce if payment is made for coverage. Your former spouse must have been covered under this group policy on the day before the entry of a valid decree of dissolution of marriage.

Your dependent's coverage will end on the earliest date:

- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions stop
- The date your former spouse remarries

To request extension of coverage you can just call the toll-free Member Services number on your ID card. Your dependents may pay up to 102% of the total plan costs.

**How can you extend coverage for a dependent that no longer qualifies as a dependent under the plan?**

Your dependent child can continue coverage when they no longer qualify as a dependent under the plan if payment is made for the coverage.

Your dependent's coverage will end on the earliest date:

- The end of the 36 month period after the date they no longer qualify as a dependent under the plan
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions stop

To request extension of coverage you can just call the toll-free Member Services number on your ID card. You may pay up to 102% of the total plan costs.

**How can you extend coverage for a dependent after you enroll in Medicare?**

Your dependents can continue coverage after you enroll in Medicare if payment is made for the coverage.

Your dependent's coverage will end on the earliest date:

- The end of the 36 month period after you enroll in Medicare
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions stop
- The date your spouse remarries

To request extension of coverage you can just call the toll-free Member Services number on your ID card. You may pay up to 102% of the total plan costs.

**When you are injured**

The following will only apply after you have received a full recovery from another source.

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

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

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

## **Jaw joint disorder**

This is:

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

## **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 judgment

## **Medically necessary/medical necessity (mental health)**

Health care services a **provider** exercising prudent clinical judgment, would provide to you 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, level, setting and duration, and considered effective for your **illness, injury** or disease

Generally accepted standards of medical practice parameters are:

- Consistent with the standards in the same or similar general specialty that typically manage the



condition, procedure or treatment and must:

- Help restore or maintain your health
- Prevent deterioration of your condition

## **Telemedicine**

A consultation between you and a **provider** 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

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

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



Dan Finke

President

Aetna Life Insurance Company

(A Stock Company)

Amendment: Minnesota Medical ET

Issue Date: February 2, 2022

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

**Important note:** The following apply only if you live in Mississippi. The benefits below will apply instead of those in your booklet-certificate.

### Retail Pharmacy

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

### Timely payment of claims

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

A clean claim does not include any other the following:

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

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

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

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

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

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

### **Payment of claims**

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed in this policy and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such

beneficiary or to such estate. All other indemnities will be payable to the insured. When payments of benefits are made to an insured directly for medical care or services rendered by a health care provider, the health care provider shall be notified of such payment. If the insured provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the insurer shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the **provider**, who may not bill or collect from the insured any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the insured that are noncovered benefits.

## Complaints, claim decisions and appeal procedures

### The difference between a complaint and an appeal

#### Complaint

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

#### Appeal

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

### Claim decisions and appeal procedures

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

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

### Appeal of an adverse benefit determination

#### Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

#### Any other claim appeal

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

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by

contacting us. You need to include:

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

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

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

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

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

## External review

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

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

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

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

You must submit the request for external review form:

- To the U.S. Office of Personnel Management
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the

review

- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

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

### **How long will it take to get an ERO decision?**

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

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

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

#### **For initial adverse benefit determinations**

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

#### **For final adverse determinations**

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

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

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

### **Utilization review**

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

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

### **Recordkeeping**

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

### **Fees and expenses**

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

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



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

Amendment: Mississippi Medical ET  
Issue Date: February 2, 2022

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

**Important note:** The following apply only if you live in New Jersey. The benefits below will apply instead of those in your booklet-certificate.

### Civil union partners

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

- Your civil union partner who meets any policyholder rules and requirements under state law.

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: New Jersey Medical ET

Issue Date: February 2, 2022





# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

**Important note:** The following apply only if you live in Pennsylvania. The benefits below will apply instead of those in your booklet-certificate.

<b>Preventive care immunizations</b>	
Performed in a facility or at a <b>physician's</b> office	0% per visit  No <b>deductible</b> applies
No <b>deductible</b> applies to childhood immunizations	
	Subject to any age and visit limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.

### Routine cancer screenings

**Eligible health services** include the following routine cancer screenings:

- Mammograms, including:
  - two and three-dimensional
  - women under age 40 when recommended by a **physician**
  - annually for women age 40 and older

- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Cytology tests
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Any combination of colorectal cancer screening tests when prescribed by your **physician**. If you are at high risk for colorectal cancer and under the age of 50, you may be eligible for any combination of colorectal cancer tests based on the American Cancer Society guidelines.
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

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

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

## 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. No deductible applies unless this benefit is provided under a qualified High Deductible Plan.

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, made of 100% free amino acids as the protein source, 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.

When **prescription drugs** are obtained at a **retail pharmacy** there will be no difference in **copayments, deductibles**, or maximum day supply than if you obtained the same **prescription drugs** using **mail order pharmacy**.

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: Pennsylvania Medical ET

Issue Date: February 2, 2022



# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pace University

**Group policy number:** GP-0181579

**Amendment effective date:** January 1, 2022

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

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

### Domestic Partners

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

- Your domestic partner and their dependent children

### Adding new dependents

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

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

### Mammograms

**Eligible health services** include the following routine cancer screenings:

- Mammograms, including 3-D mammograms (tomosynthesis)

## Neurodevelopmental therapy

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

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

## Home health care

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

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

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

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

## Exclusions

Your plan does not cover the following under this section:

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

## Hospice care

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

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

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

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

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

### **Exclusions**

Your plan does not cover the following under this section:

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

### **Abortion**

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

### **Acupuncture**

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

### **Nutritional supplements**

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

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

### **Exclusions**

Your plan does not cover the following under this section:

Any food item, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered above

### **Jaw joint disorder treatment**

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

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

dysfunction (MPD)

The following are not covered under this benefit:

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

## **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.

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

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

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

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

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

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

## **Coordination of benefits**

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

## **Key terms**

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

Allowable expense means:

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

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

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



## Here's how COB works

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

## Determining who pays

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

<b>If you are covered as a:</b>	<b>Primary plan</b>	<b>Secondary plan</b>
Non-dependent or dependent	The plan covering you as a non-dependent	The plan covering you as a dependent
Exception to the rule above when you are eligible for Medicare	If you or your spouse has Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: <ul style="list-style-type: none"> <li>• <b>Online:</b> Log on to your <b>Aetna</b> secure member website at <a href="http://www.aetna.com">www.aetna.com</a></li> <li>• <b>By phone:</b> Call the number on your ID card</li> </ul>	
<b>COB rules for dependent children</b>		
Child of: <ul style="list-style-type: none"> <li>• Parents who are married or living together</li> </ul>	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the <b>calendar year</b> .  *Same birthdays-the plan that has covered a parent longer is primary.	The plan of the parent born later in the year (month and day only).*  *Same birthdays-the plan that has covered a parent longer is primary.
Child of: <ul style="list-style-type: none"> <li>• Parents separated or divorced or not living together</li> <li>• With court-order</li> </ul>	The plan of the parent whom the court said is responsible for health coverage.  But if that parent has no coverage then their spouse's plan is primary.	The plan of the other parent.  But if that parent has no coverage, then their spouse's plan is primary.
Child of: <ul style="list-style-type: none"> <li>• Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody</li> </ul>	Primary and secondary coverage is based on the birthday rule.	
Child of: <ul style="list-style-type: none"> <li>• Parents separated or divorced or not living together and there is no court-order</li> </ul>	The order of benefit payments is: <ul style="list-style-type: none"> <li>• The plan of the custodial parent pays first</li> <li>• The plan of the spouse of the custodial parent (if any) pays second</li> <li>• The plan of the noncustodial parents pays next</li> <li>• The plan of the spouse of the noncustodial parent (if any) pays</li> </ul>	

	last	
Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination. See <i>Child of</i> content above.	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

### How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	<p>The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan.</p> <p>The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.</p>
Benefit reserve  Each family member has a separate benefit reserve for each <b>calendar year</b>	<p>The benefit reserve:</p> <ul style="list-style-type: none"> <li>• Is made up of the amount that the secondary plan saved due to COB</li> <li>• Is used to cover any unpaid allowable expenses</li> <li>• Balance is erased at the end of each year</li> </ul>

### How COB works with Medicare

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

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

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

- Age
- Disability
- End stage renal disease

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

### Who pays first?

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

This plan is secondary to Medicare in all other circumstances.

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

### Other health coverage updates – contact information

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

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

### Right to receive and release needed information

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

### Right to pay another carrier

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

## Right of recovery

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

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

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

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

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

## When you disagree - claim decisions and appeals procedures

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

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

## Claim procedures

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

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none"> <li>• You should notify and request a claim form from us</li> <li>• The claim form will provide instructions on how to complete and where to send the form(s)</li> </ul>	<ul style="list-style-type: none"> <li>• You must send us notice and proof as soon as reasonably possible</li> <li>• If you are unable to complete a claim form, you may send us: <ul style="list-style-type: none"> <li>– A description of services</li> <li>– Bill of charges</li> <li>– Any medical documentation you received from your provider</li> </ul> </li> </ul>
Proof of loss (claim)	<ul style="list-style-type: none"> <li>• A completed claim form and any additional information required by us</li> </ul>	<ul style="list-style-type: none"> <li>• You must send us notice and proof as soon as reasonably possible</li> </ul>
Benefit payment	<ul style="list-style-type: none"> <li>• Written proof must be provided for all benefits</li> <li>• If we challenge any portion of a claim, the unchallenged portion of</li> </ul>	<ul style="list-style-type: none"> <li>• Benefits will be paid as soon as the necessary proof to support the claim is received</li> </ul>

	the claim will be paid promptly after the receipt of proof of loss	
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## Types of claims and communicating our claim decisions

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

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

### Urgent care claim

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

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

### Pre-service claim

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

### Post-service claim

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

### Concurrent care claim extension

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

### Concurrent care claim reduction or termination

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

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

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

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

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

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

### Adverse benefit determinations

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

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

We may sometimes:

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

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

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

Reasons for adverse benefit determinations may be:

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

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

## The difference between a grievance and an appeal

### A grievance

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

### An appeal

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

## Appeals of adverse benefit determinations

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

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

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

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

## Urgent care or pre-service claim appeals

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

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

## Timeframes for deciding appeals

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

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

### Exhaustion of appeals process

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

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

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

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

### External review

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

You have a right to external review if:

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

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

You must submit the Request for External Review Form:

- To **Aetna**
- Within 180 calendar days of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request



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

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

The ERO will:

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

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

### **How long will it take to get an ERO decision?**

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

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

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

#### **For initial adverse determinations**

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

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

#### **For final adverse determinations**

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

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

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

### **Recordkeeping**

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

### **Fees and expenses**

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

## **Out-of-network benefits disclosure**

### **Your health plan's out-of-network benefits**

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

### **Notice of consumer rights**

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

### **Out-of-network costs**

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

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

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

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

### **How to use the transparency tool**

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

### **Search our network for doctors, hospitals and other health care providers**

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

Visit [Aetna.com](https://www.aetna.com) and log in. From your secure member website home page, select "Find Care" from the menu bar and start your search.

Our online search tool is more than just a list of doctors' names and addresses. It also includes information about:

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

- Gender
- Driving directions

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

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

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

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

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

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



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

Amendment: Washington Medical ET  
Issue Date: February 2, 2022