BENEFIT PLAN

Prepared Exclusively For
TW Ventures Inc.

OA Managed Choice POS HDHP

Extraterritorial Riders

Aetna Life Insurance Company

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

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Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: TW Ventures Inc.

Group policy number: GP-861495-C

Amendment effective date: August 1, 2019

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 unless the benefits in your booklet-certificate are better.

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.

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.

ART services

ART services include:

- In vitro fertilization (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Gamete intrafallopian transfer (GIFT)
- Cryopreserved embryo transfers (Frozen Embryo Transfers (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery

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	**A**. 6 months or more **or** 	**B**. At least 6 cycles of donor insemination	6 months	**If you are less than age 40**, 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. **If you are age 40 and older**, 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.

A female 35 years of age or older without a male partner	Does not apply	At least 6 cycles of donor insemination	6 months	**If you are less than age 40**, 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. **If you are age 40 and older,** 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.
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, so long as egg retrievals are completed before you reach age 45 and transfers are completed before you reach age 50, 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 fertile
- Have planned services that will result in infertility such as:
  - Chemotherapy
  - Pelvic radiotherapy
  - Other gonadotoxic therapies
  - Ovarian or testicular removal

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

- You, your partner or dependent child are planning treatment that is demonstrated to result in **infertility**. Planned treatments include:
  - Bilateral orchiectomy (removal of both testicles)
  - Bilateral oophorectomy (removal of both ovaries)
  - Hysterectomy (removal of the uterus)
  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
- 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	**If you are less than age 40**, must be less than 19 mIU/mL in your most recent lab test. **If you are age 40 and older**, 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.

Infertile/infertility

A disease defined by the failure to become pregnant or an inability to carry a pregnancy to live birth:

- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart

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.

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.

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.

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

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Delaware Medical ET
Issue Date: June 19, 2019

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: TW Ventures Inc.

Group policy number: GP-861495-C

Amendment effective date: August 1, 2019

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

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

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION

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

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

- Your spouse
- Your domestic partner.
- Your dependent children – your own or those of your spouse or domestic partner
  - The children must be under 26 years of age, and they include:
    - Your biological children
    - Your stepchildren
    - Your legally adopted children
    - Your foster children, including any children placed with you for adoption
    - Any children you are responsible for under a qualified medical support order or court-order (without regard to whether or not the child resides with you)
    - Your 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.

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 without a **referral**.

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**.

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

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Florida Medical ET
Issue Date: June 19, 2019

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

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: TW Ventures Inc.

Group policy number: GP-861495-C

Amendment effective date: August 1, 2019

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

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

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 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.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms – including baseline
- 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
- CA-125 serum tumor marker testing; transvaginal ultrasound; and rectovaginal pelvic exam for women age 35 and over who are at risk of ovarian cancer
- 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 without a **referral**.

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.
- 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.**
- Anesthesia and hospital charges for dental care, if:
  - You are 7 years old or younger or are developmentally disabled.
  - A successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition.
  - You have sustained extensive facial or dental trauma, unless otherwise covered by worker's compensation.

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 the following treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan:

- Behavioral health treatment
- Habilitative and rehabilitative services
- Counseling services
- Therapy services
- Applied behavioral analysis

Eligible health services for the treatment of autism spectrum disorder will not count toward the number of visits for the following:

- Physical therapy
- Occupational therapy
- Speech therapy

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.

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

Jaw joint disorder treatment

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

In no event will the covered amount for Out-Of-Network charges be less than 30% of the covered amount for In-Network charges.

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

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Georgia Medical ET
Issue Date: June 19, 2019

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: TW Ventures Inc.

Group policy number: GP-861495-C

Amendment effective date: August 1, 2019

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

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

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

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

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

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

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

- Your spouse
- Your civil union partner. In accordance with the Illinois Religious Freedom Protection and Civil Union Act (750 ILCS 75/), a "civil union" means a legal relationship between 2 persons, of either the same or opposite sex
- Your domestic partner who meets the rules set by the **policyholder**.
  - To be eligible for coverage, a domestic partner is a person who certifies the following as of the date of enrollment:
    - He or she is your sole domestic partner and intend to remain so indefinitely
    - He or she is not be married or legally separated from anyone else
    - He or she is not registered as a member of another domestic partnership within the past 6 months
    - He or she is of the age of consent in your state of residence
    - He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside
    - He or she has cohabitated and resided with you in the same residence for the past 6 months and intends to cohabitate and reside with you indefinitely
    - He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses
    - He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage
    - He or she is can demonstrate interdependence with you by submitting proof of at least three of the following:
      - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property
      - Common ownership of a motor vehicle
      - Driver's license with a common address
      - Proof of joint bank accounts or credit accounts
      - Proof of designation as the primary beneficiary for life insurance or retirement benefits or primary beneficiary designation under your will
      - Assignment of a durable property power of attorney or health care power of attorney.
- Your dependent children – your own or those of your spouse, civil union partner or domestic partner
  - The children must be under 26 years of age, and they include:
    - Your biological children
    - Your stepchildren
    - Your legally adopted children
    - Your foster children, including any children in your custody due to an interim court order of adoption or placed with you for adoption
    - Any children you are responsible for under a qualified medical support order or court-order (without regard to whether or not the child resides with you)
    - Your grandchildren in your court-ordered custody
    - Any other child with whom you have a parent-child relationship
    - Your military veteran dependent who:
      - Is unmarried
      - Is under age 30
      - Is a resident of Illinois
      - Served as a member of the active or reserve component of the United States Armed Forces, including the Illinois National Guard

- Received a discharge release, other than a dishonorable discharge.

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.

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:
  - Haemophilius 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.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms, including:
  - For woman over 35, a low dose mammography. This includes a digital mammography and breast tomosynthesis
  - A screening MRI, as determined by your **physician**.
  - For women 35-39, a baseline mammogram
  - For women 40 years of age and older, an annual mammogram
  - For woman under 40, with a family history of breast cancer or other risk factors, at necessary age and intervals
  - Comprehensive ultrasound screening of the entire breast(s) when a mammogram shows it is needed.
- Annual digital rectal exams and prostate specific antigen (PSA) tests as recommended by your **physician**. This includes:
  - Asymptomatic men age 50 and older
  - African-American men age 40 and over
  - Men age 40 and over with family history of prostate cancer
- Colorectal cancer screening for adults over 50
- 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: adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years.

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.

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**.

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.

Nutritional supplements

Eligible health services include amino acid-based formula products order by a **physician** for the treatment of eosinophilic disorders or short bowel syndrome, regardless of the delivery method.

Eligible health services also 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.

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	• You should notify and request a claim form from the policyholder. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send us notice and proof as soon as reasonably possible. • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges – Any medical documentation you received from your provider
Proof of loss (claim)	• A completed claim form and any additional information required by us.	• You must send us notice and proof as soon as reasonably possible.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid within 30 days after the necessary proof to support the claim is received. • 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.

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

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Illinois Medical ET
Issue Date: June 19, 2019

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: TW Ventures Inc.

Group policy number: GP-861495-C

Amendment effective date: August 1, 2019

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

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

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
        - A grandchild whose parent is already covered as a dependent under this plan
        - Any other child with whom you have a parent-child relationship

"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**, **PCP** 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.

Well woman preventive visits routine gynecological exams (including annual pap smears)		
Performed at a **physician's**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies	80% (of the **recognized charge**) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	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	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 **network provider** who is an OB, GYN or OB/GYN.

Routine cancer screenings **(applies whether performed at a physician's, PCP, specialist office or facility)**		
Mammograms 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)	100% per visit No **deductible** applies	80% (of the **recognized charge**) per visit
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.

Prostate specific antigen (PSA) test and Digital rectal exam (DRE)	100% per visit No **deductible** applies	80% (of the **recognized charge**) per visit
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.
Colonoscopies One every 10 years beginning at age 50 (or age 45 for African Americans)	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.

Sigmoidoscopies	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.
Fecal Immunochemical Test for blood (FIT)	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. • Current recommendations established by the American College of Gastroenterology (ACOG) in consultation with the American Cancer Society. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. • Current recommendations established by the American College of Gastroenterology (ACOG) in consultation with the American Cancer Society. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.

Other routine cancer screening	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		

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.

Autism spectrum disorder		
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
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.	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 **illness** 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.

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

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services. After 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	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

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

Hearing aids and exams for minors		
Hearing aid exams Covered person through age 25	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Hearing aids Covered person through age 25	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Hearing aids	One per ear every 36 month consecutive period.	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.

Nutritional supplements		
Nutritional supplements	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

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

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

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

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

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.

	If you are a new enrollee and your provider is an out-of-network provider	**When your provider stops participation with Aetna**
Request for approval	You need to complete a Transition Coverage Request form and send it to us. You can get this form by calling the toll-free number on your ID Card	You or your **provider** should call **us** for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the **provider** terminated their participation with **us.**

If you are pregnant and have entered your second trimester, 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

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	• You should notify and request a claim form from your employer. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send us notice and proof as soon as reasonably possible. • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges – Any medical documentation you received from your **provider**
Proof of loss (claim)	• A completed claim form and any additional information required by us.	• You must send us notice and proof as soon as reasonably possible.
Benefit payment	• Written proof must be provided for all benefits. • If we challenge any portion of a claim , the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

You or your **provider** is required to send us a claim in writing. 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.ldi.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 s**tay** 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**
Standard external review	Within 5 business days	Within 1 business day after receiving request from **Aetna**	Within 45 days after the date of receipt of the request
Expedited external review (oral or written)	Immediately after receiving request	Immediately after receiving request from **Aetna**	As soon as possible but no longer than 72 hours after getting assigned
Standard external review of experimental or investigational treatment adverse determinations	• Within 5 business days after receiving request to determine eligibility	Within 1 business day after the date of receiving request from **Aetna**	Within 20 days after the date it receives the opinion of each clinical peer to make a decision (clinical peers have 20 days to provide a written opinion to IRO)

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

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.

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Louisiana ET Rider
Issue Date: June 19, 2019

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: TW Ventures Inc.

Group policy number: GP-861495-C

Amendment effective date: August 1, 2019

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 unless the benefits in your booklet-certificate are better.

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.

New insureds

To the group or class thereof originally insured may be added, from time to time, all new employees of the employer, members of the association, or debtors of the creditor eligible to and applying for insurance in the group or class and covered or to be covered by the master policy.

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.

Dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this provision.

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 II 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 treatment and non-surgical treatment of **jaw joint disorder** by a **provider** or dental **provider**. Coverage will be provided the same as for any other joint in the body under this plan.

Lyme disease

Eligible health services include treatment of diagnosed Lyme disease.

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**, including court-ordered 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)
    - Mental health injectables
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23-hour observation
- **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 by 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 questions related to **DME**, call us at the telephone number listed on your ID card.

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.

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

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

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

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

	If you are a new enrollee and your provider is an out-of-network provider	**When your provider stops participation with Aetna**
Request for approval	You need to complete a Transition Coverage Request form and send it to us. You can get this form by calling the toll-free number on your ID card.	You or your **provider** should call **us** for approval to continue any care.
Length of transitional period	Care will continue during a transitional, 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 **provider** terminated their participation with **us**.

	If you are a new enrollee and your provider is not contracted with Aetna
Request for approval	You need to complete a Transition of Coverage Request form and send it to us. You can get this form by calling the toll-free number on your ID card.
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 **network provider** 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	• You should notify and request a claim form from the policyholder. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send us notice and proof as soon as reasonably possible. • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges • Any medical documentation you received from your **provider**
Proof of loss (claim)	• A completed claim form and any additional information required by us.	• You must send us notice and proof as soon as reasonably possible
Benefit payment	• Written proof must be provided for all benefits. • If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

You or your **provider** 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.
- Consistent with the standards set forth in policy issues involving 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

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

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Minnesota Medical ET
Issue Date: June 19, 2019

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: TW Ventures Inc.

Group policy number: GP-861495-C

Amendment effective date: August 1, 2019

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

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

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

Pre-Service Claim Determinations

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

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

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

Post-Service Claim Determinations

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

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

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: New York Medical ET
Issue Date: June 19, 2019

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: TW Ventures Inc.

Group policy number: GP-861495-C

Amendment effective date: August 1, 2019

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 unless the benefits in your booklet-certificate are better.

Preventive care immunizations		
Performed in a facility or at a **physician's** office No **deductible** applies to childhood immunizations	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on 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 without a **referral**.

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, 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.

Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Pennsylvania Medical ET
Issue Date: June 19, 2019