BENEFIT PLAN

Prepared Exclusively for
TW Ventures Inc.

OA Managed Choice POS

Extraterritorial Riders

Aetna Life Insurance Company

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

Proprietary

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Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	TW Ventures Inc.
Group Policy No.:	GP-861495-C
Rider:	Alabama ET Medical
Issue Date:	June 19, 2019
Effective Date:	August 1, 2019

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Alabama. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Alabama, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Autism Spectrum Disorders (GR-9N 11-171 06)

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

Covered expenses include charges made by a **physician** or **behavioral health provider** for services and supplies for the screening, diagnosis and treatment, (including behavioral therapy and Applied Behavioral Analysis), of Autism Spectrum Disorder when ordered by a **physician or a behavioral health provider;** and the covered expenses are incurred prior to attainment of age nineteen.

Coverage also includes certain early intensive behavioral interventions such as Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that:

- Systematically change behavior; and
- Are responsible for the observable improvement in behavior.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network retail pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a network **mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a network **mail order pharmacy**. **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**.

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Pharmacy Benefit Limitations *(GR-9N 13-015 07 CA)*

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

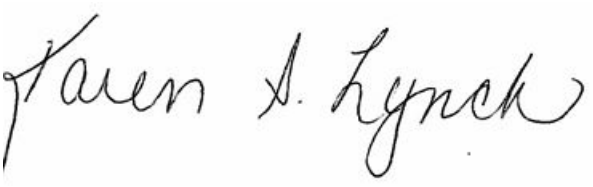
The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

You will be charged the **out-of-network prescription drug cost sharing** for **prescription drugs** recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet-Certificate.

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

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



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

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

Proprietary

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	TW Ventures Inc.
Group Policy No.:	GP-861495-C
Rider:	Arizona ET Medical
Issue Date:	June 19, 2019
Effective Date:	August 1, 2019

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Arizona. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Arizona, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.

Family Planning Services *(GR-9N-11-005-01 AZ)*

Covered expenses include charges for certain contraceptive services even though not provided to treat an **illness** or **injury**.

Contraception Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Autism Spectrum Disorders *(GR-9N 11-171-04 AZ)*

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

Covered expenses include charges made by a **physician** or **behavioral health provider** for services and supplies for the diagnosis and treatment of Autism Spectrum Disorder. The services and supplies must be ordered by a **physician** or a **behavioral health provider.**

Coverage also includes early intensive behavioral interventions such **as Applied Behavioral Analysis (ABA).** Applied Behavioral Analysis is an educational service that is the process of applying interventions that:

- Systematically change behavior; and
- Are responsible for the observable improvement in behavior.

Coverage for behavioral therapy and Applied Behavioral Analysis for Autism Spectrum Disorders is subject to the maximum benefit amount, if any, shown on the Schedule of Benefits.

Limitations:
Unless specified above, not covered under this benefit are charges for:

- Educational services for behavioral disorders are listed as not covered in the Medical Plan Exclusions and Limitations section of the Policy.

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References to subrogation, if any, have been removed from the *General Provisions* section of your Booklet-Certificate and no longer apply to your plan of benefits.

Appeals Procedure – Health Care Coverage *(GR-9N-32-050-01-AZ)*

Getting Information about the Health Care Appeals Process

We must send you a copy of the Arizona Appeals Information Packet when you first receive your policy, and within 5 business days after we receive your request for an **appeal**. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of the Arizona Appeals Information Packet. We will also send a copy of the Arizona Appeals Information Packet to you or your treating **provider** at any time upon request. To request a copy, just call the Member Services number printed on your Member ID Card.

At the back of the Arizona Appeals Information Packet, you will find forms you can use for your **appeal**. The Arizona Insurance Department ("the Department") developed these forms to help people who want to file a health care **appeal**. You are not required to use them. We cannot reject your **appeal** if you do not use them. If you need help in filing an **appeal**, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at 602-364-2499 or 1-800-325-2548 (inside Arizona but outside the Phoenix area), or via the internet at http://www.azinsurance.gov, or you may call us at 1-800-756-7039.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to **appeal** that decision. Your notice may come directly from us, or through your treating **provider**.

Decisions You Can Appeal

You can **appeal** the following decisions:

1. We do not approve a service that you or your treating **provider** has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not "medically necessary".
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.

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5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.
7. You disagree with our decision to issue or not issue a policy to you.

Decisions You Cannot Appeal

You cannot **appeal** the following decisions:

1. You disagree with our decision as to the amount of "usual, customary, and reasonable charges". Where applicable, a usual, customary, and reasonable charge is a charge for a covered benefit which is determined by us to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. We may take into account factors such as the complexity, degree of skill needed, type or specialty of the **provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the usual, customary, and reasonable charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of **provider**s in the area.
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your Plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You are dissatisfied with any rate increases you may receive under your insurance policy.
6. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that cannot be appealed according to this list, you may still file a complaint with us by calling our Customer Services Department at the number printed on your Member ID Card. In addition, you may also file such complaints with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th Street, Second Floor, Phoenix, AZ 85018.

Who Can File an Appeal

Either you or your treating **provider** can file an **appeal** on your behalf. At the end of the Arizona Appeals Information Packet is a form that you may use for filing your **appeal**. You are not required to use this form. If you wish, you can send us a letter with the same information. If you decide to **appeal** our decision to deny authorization for a service, you should tell your treating **provider** so the **provider** can help you with the information you need to present your case.

DESCRIPTION OF THE APPEALS PROCESS

I. Levels of Review

We offer expedited as well as standard appeals for Arizona residents. Expedited appeals are for urgently needed services that you have not yet received. Standard appeals are for non-urgent service requests and denied claims for services already provided. Both types of appeals follow a similar process, except that we process expedited appeals much faster because of the patient's condition.

Each type of **appeal** has three levels, as follows:

Expedited Appeals (For urgently needed service you have claims)	**Standard Appeals** (For non-urgent services or denied not yet received)
Level One: Expedited Medical Review	Informal Reconsideration
Level Two: Expedited Appeal	Formal Appeal
Level Three: Expedited External, Independent Medical	External, Independent Medical Review

We make the decisions at Level One and Level Two. An outside reviewer, who is completely independent from Aetna, makes Level Three decisions. You are not responsible to pay the costs of the external review if you choose to **appeal** to Level Three. These three levels of Appeals are discussed more fully below:

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Before requesting a level three, you must exhaust the internal **appeal** process unless:

- We waive the exhaustion requirement
- We fail to comply with the requirements of the internal **appeal** process except failures that are based on *de minimis* violations
- You request a simultaneous expedited internal and external **appeal**.

You may supply additional information that you would like us to consider. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting us at the number on your member identification card.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited Medical Review (Level One)

Your Request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:

- You have coverage with us;
- We denied your request for a covered service; and
- Your treating **provider** certifies that the time required to process your request through the Informal Reconsideration (Level One) and Formal Appeal (Level Two) **appeal** process (about 30 days) is likely to cause a significant negative change in your medical condition. (At the end of the Arizona Appeals Information Packet is a form that your **provider** may use for this purpose. Your **provider** could also send a letter or make up a form with similar information.) Your treating **provider** must send the certification and documentation to:

Name:	Aetna Life Insurance Company
Title:	Customer Resolution Team
Address:	P.O. Box 14002, Lexington, KY 40512
Phone:	1-877-665-6736
Fax:	860-754-5321

Our Decision: We must call and inform you and your treating **provider** of our decision within **1 business day or 36 hours from request receipt, whichever is less**. We will then mail our decision in writing to both you and your treating **provider**. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately **appeal** to Level Two.

If we grant your request: We will authorize the service and the **appeal** process is complete.

If we refer your case to Level Three: We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

Expedited Appeal (Level Two)

Your request: If we deny your request at Level One, you may request an Expedited Appeal. After you receive our Level One denial, your treating **provider *must immediately*** send us a request (to the same person and address listed above under Level One) to tell us you are appealing to Level Two. To help your **appeal**, your **provider** should also send us any more information that the **provider** hasn't already sent us to show why you need the requested service.

Our Decision: We must call and inform you and your treating **provider** of our decision within **1 business day or 36 hours from request receipt, whichever is less**. We will then mail our decision in writing to both you and your treating **provider**. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

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If we deny your request: You may immediately **appeal** to Level Three.

If we grant your request: We will authorize the service and the **appeal** process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Informal Reconsideration (Level One)

Your request: You may obtain Informal Reconsideration of your denied request for a service or a denied claim for services already provided to you if:

- You have coverage with us;
- We denied your request for a covered service or denied your claim for services already provided,
- You do not qualify for an expedited **appeal**, and
- You or your treating **provider** asks for Informal Reconsideration within 2 years of the date we first deny the requested service or claim by calling, writing, or faxing your request to:

Name:	Aetna Life Insurance Company
Title:	Customer Resolution Team
Address:	P.O. Box 14002, Lexington, KY 40512
Phone:	1-800-545-2211
Fax:	859-425-3379

Our acknowledgement: Aetna has 5 business days after we receive your request for Informal Reconsideration ("the receipt date") to send you and your treating **provider** a notice that we received your request.

Our decision: Aetna has the following timeframes after the receipt date within which to decide whether we should change our decision and authorize your requested service or pay your claim. Within that same timeframe, we must send you and your treating **provider** our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim--within 15 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have 60 days to appeal to Level Two.**

If we deny your request for a Concurrent Care Claim Extension--within 15 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have 60 days to appeal to Level Two.**

If we deny your request for a Post-Service Claim--within 30 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have 60 days to appeal to Level Two**.

If we grant your request: The decision will authorize the service or pay the claim and the **appeal** process is complete.

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If we refer your case to Level Three: We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

You must exhaust the internal **appeal** process unless:

- We waive the exhaustion requirement
- We fail to comply with the requirements of the internal **appeal** process except for failures that are based on unimportant or minor violations

Formal Appeal (Level Two)

Your request: You may request Formal Appeal if we denied your request or claim at Level One. After you receive our Level One denial, you or your treating **provider** must send us a written request within 60 days to tell us you are appealing to Level Two. To help us make a decision on your **appeal**, you or your treating **provider** should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

A Member and/or an authorized representative may attend the Level Two Appeal hearing and question the representative of Aetna and/or any other witnesses, and present their case. The hearing will be informal. A Member's Physician or other experts may testify. Aetna also has the right to present witnesses.
Send your **appeal** request and information to:

Name: Aetna Life Insurance Company
Title: Customer Resolution Team
Address: P.O. Box 14002, Lexington, KY 40512

Phone: 1-800-545-2211
Fax: 859-425-3379

Our acknowledgement: Aetna has 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating **provider** a notice that we received your request.

Our decision: For a denied service that you have not yet received, Aetna has the following timeframes after the receipt date within which to decide whether we should change our decision and authorize your requested service. We will send you and your treating **provider** our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim--within 15 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have four months to appeal to Level Three.**

If we deny your request for a Concurrent Care Claim Extension--within 15 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have four months to appeal to Level Three.**

If we deny your request for a Post-Service Claim--within 30 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have four months to appeal to Level Three**.

If we grant your request: We will authorize the service or pay the claim and the **appeal** process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

II. The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires "any Member who files a Complaint or Appeal with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for decisions that are

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appealable, you must pursue the health care Appeals process before the Director of Insurance can investigate a Complaint or Appeal you may have against Aetna based on the decision at issue in the Complaint or Appeal.

The Appeal process requires the Director to:

1. Oversee the Appeals process.
2. Maintain copies of each utilization review Plan submitted by Aetna.
3. Receive, process, and act on requests from Aetna for External Independent Medical Review.
4. Enforce the decisions of Aetna.
5. Review decisions of Aetna.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an Appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at the OAH.

III. Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits the Member to ask for a copy of their medical records. Your request must be in writing and must specify who you want to receive the records. The health care **Provider** who has your records will provide you or the person you specify with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to you or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the Appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

IV. Documentation for an Appeal

If you decide to file an Appeal, the Member must give us any material justification or documentation for the Appeal at the time the Appeal is filed. If you gather new information during the course of your Appeal, you should give it to us as soon as you receive it. You must also give Aetna the address and phone number where you can be contacted. If the Appeal is already at Expedited External Independent Medical Review, you should also send the information to the Department of Insurance.

V. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed (your last known address) on the fifth business day after being mailed.

VI. Record Retention

Aetna shall retain the records of all Complaints and Appeals for a period of at least 7 years.

VII. Fees and Costs

Nothing herein shall be construed to require Aetna to pay counsel fees or any other fees or costs incurred by a Member in pursuing a Complaint or Appeal.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it

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cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including Plan limitations or exclusions.

Appeal: An written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

External Independent Review *(GR-9N-32-051-01-AZ)*

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited External, Independent Review (Level Three)
Your request: You may Appeal to Expedited External Independent Medical Review only after you have appealed through Level Two. You have four months after you receive Aetna's Level Two decision to send Aetna your written request for Expedited External Independent Medical Review. Your request should include any additional information to support your request for the service. Your written request for Expedited External Independent Medical Review should be sent to:

Name:	Priscilla Bugari, R.N.
Title:	Director, Aetna National External Review Unit
Address:	1100 Abernathy Rd, Suite 375, Atlanta, GA 30328
Phone:	1-877-848-5855 (Toll-free number)
Fax:	860-975-1526

You and your treating **provider** are not responsible for the cost of any Expedited External Independent Medical Review.

Process

There are 2 types of Expedited External Independent Medical Review Appeals, depending on the issues in your case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) you or your treating Provider are asking for, are not Medically Necessary to treat your condition. The expedited external independent reviewer is a Provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Department of Insurance, and not connected with Aetna. The IRO Provider must be a Provider who typically manages the condition under review.

   Within 1 business day of receiving your request, Aetna must:

   - Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating Provider.
   - Send the Director of Insurance: the request for review; your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision; the criteria used and clinical reasons for

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Aetna's decision; and the relevant portions of Aetna utilization review guidelines. Aetna must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving Aetna information, the Director of Insurance must send all the submitted information to an expedited, external independent reviewer organization (the "IRO").

Within 72 hours of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

Within 48 hours of receiving the IRO's decision, the Director of Insurance must mail a notice of the decision to Aetna, you, and your treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under your Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Department of Insurance is the expedited external independent reviewer.

   Within 1 business day of receiving your request, Aetna must:

   - Mail a written acknowledgement of your request to the Director of Insurance, you, and your treating Provider.
   - Send the Director of Insurance: the request for review, your Aetna Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna's utilization review guidelines.

   Within 2 business days of receiving this information, the Director of Insurance must determine if the service or claim is covered, issue a decision, and send a notice to Aetna, you, and your treating Provider.

   The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs, the Director of Insurance will forward your case to an IRO. The IRO will have 72 hours to make a decision and send it to the Director of Insurance. The Director of Insurance will have 48 hours after receiving the IRO's decision to send the decision to Aetna, you, and your treating Provider.

Decision

Medical Necessity Decision: If the IRO decides that Aetna should provide the service, Aetna must authorize the service. If the IRO agrees with Aetna decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Decision: If you disagree with the Director of Insurance's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be scheduled within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for Appeals from Expedited External Independent Medical Review Appeals decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

External, Independent Review (Level Three)

Your request: You may obtain External Independent Medical Review only after you have sought any Appeals through standard and expedited Level One and Level Two. You have four months after receipt of written notice from Aetna that your Formal Appeal or Expedited Medical Review has been denied to request External Independent Medical Review. You must send a written request for External Independent Medical Review and any material justification or documentation to support your request for the covered service or claim for a covered service to:

Name: Priscilla Bugari, R.N.

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Title:	Director, Aetna National External Review Unit
Address:	1100 Abernathy Rd, Suite 375, Atlanta, GA 30328
Phone:	1-877-848-5855 (Toll-free number)
Fax:	860-975-1526

Neither you nor your treating Provider is responsible for the cost of any External Independent Medical Review.

Process

There are 2 types of External Independent Medical Review Appeals, depending on the issues in your case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) you or your treating Provider are asking for, are not Medically Necessary to treat your condition. The external independent reviewer is a Provider retained by an outside Independent Review Organization ("IRO") that is procured by the Arizona Department of Insurance, and not connected with Aetna. The IRO Provider must be one who typically manages the condition under review.

   Within 6 business days of receiving your or the Director of Insurance's request, or if Aetna initiates an External Independent Medical Review, Aetna must:

   - Mail a written acknowledgement to the Director of Insurance, you, and your treating Provider.
   - Send the Director of Insurance: the request for review; your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision; the criteria used and clinical reasons for Aetna decision; and the relevant portions of Aetna's utilization review guidelines. We must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier Appeal levels.

   Within 5 business days of receiving Aetna information, the Director of Insurance must send all the submitted information to an expedited, external independent review organization (the "IRO").

   Within 45 calendar days of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

   Within 5 business days of receiving the IRO's decision, the Director of Insurance will mail a notice of the decision to Aetna, you, and your treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under your Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Department of Insurance is the external independent reviewer.

   Within 6 business days of receiving your request or if Aetna initiates an External Independent Medical Review, Aetna must:

   - Mail a written acknowledgement of your request to the Director of Insurance, you, and your treating Provider.
   - Send the Director of Insurance: the request for review, your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna's utilization review guidelines.

   Within 15 business days of receiving this information, the Director of Insurance will determine if the service or claim is covered, issue a decision, and send a notice of determination to Aetna, you, and your treating Provider.

   The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs or if the Director of Insurance finds that the case involves a medical issue, the Director of Insurance will forward your case to an

Proprietary

IRO. The IRO will have 45 calendar days to make a decision and send it to the Director of Insurance. The Director of Insurance will have 5 business days after receiving the IRO's decision to send the decision to Aetna, you, and your treating Provider.

Decision

Medical Necessity decision: If the IRO decides that Aetna should provide the service, Aetna must authorize the service regardless of whether judicial review is sought. If the IRO agrees with Aetna's decision to deny the service, the Appeal is over. Your only further option is to pursue your claim in Superior Court. However, on written request by the IRO, you or Aetna, the Director of Insurance may extend the 45-day time period for up to an additional 30 days, if the requesting party demonstrates good cause for an extension.

Contract Coverage decision: If you disagree with the Director of Insurance's final decision on a contract coverage issue, the Member may request a hearing with the Office of Administrative Hearings ("OAH"). If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

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

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

Proprietary

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	TW Ventures Inc.
Group Policy No.:	GP-861495-C
Rider:	Arkansas ET Medical
Issue Date:	October 25, 2019
Effective Date:	September 1, 2019

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Arkansas. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Arkansas, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Important Information

In the event you need to contact someone about your insurance coverage, you may contact Aetna Life Insurance Company at the following address and telephone number:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123

If you have been unable to contact or obtain satisfaction from Aetna, you may contact the Arkansas Insurance Department at:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

Mercer, 633 W. 5th Street, Suite 1200, Los Angeles, CA 90071

How and When to Enroll *(GR-9N 29-015 01-AR)*

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

Newborns are automatically covered for 90 days after birth. To continue coverage after 90 days, you will need to complete a change form and return it to your employer within the 90-day enrollment period.

Handicapped Dependent Children *(GR-9N-31-015-01)*

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

At the request and expense of Aetna, proof that your child is fully handicapped must be submitted to Aetna by your Employer. In no event will this requirement preclude any eligible dependent, regardless of age. If such incapacity or dependency is removed or terminated, your Employer shall notify **Aetna**.

In no event will the covered amount for In-Network charges exceed more than 25% of the covered amount for Out-of-Network charges.

Diabetic Equipment, Supplies and Education

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- External insulin pumps;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Treatment of Infertility *(GR-9N 11-135-01 AR)*

Outpatient In Vitro Fertilization Expenses
Covered Expenses for outpatient in vitro fertilization procedures will be paid when they are incurred by:

- A female employee; or
- The dependent legal spouse of a male employee.

Also included are expenses incurred for cryopreservation. They will be paid on the same basis as for **illness**; but only if all these tests are met:

- The procedures are performed while the person is not confined in a **hospital** or any other facility as an inpatient.
- Her oocytes are fertilized with her husband's sperm.
- She and her husband have a history of **infertility**. It must have lasted at least 2 years; or the **infertility** is associated with one or more of these conditions:
  - Endometriosis.
  - Exposure in utero to diethylstilbestrol; known as DES.
  - Surgical removal, other than for voluntary sterilization, of one or both fallopian tubes. This is known as lateral or bilateral salpingectomy.
  - Abnormal male factors contributing to the **infertility**.
- She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.
- The in vitro fertilization procedures are performed:
  - at a medical facility licensed or certified by the Arkansas Department of Health; or certified by the Arkansas Department of Health as either.
  - meeting the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
  - meeting the American Fertility Society's minimal standards for programs of in vitro fertilization.

Not more than the **In Vitro Fertilization Maximum** will be paid in connection with all in vitro fertilization procedures in the person's lifetime.

Important Note
Treatment of **Infertility** must be pre-authorized by **Aetna**. Treatment received without pre-authorization or treatment from an **out-of-network provider** will not be covered. You will be responsible for full payment of the service.

Refer to the *Schedule of Benefits* for details about the maximums that apply to **infertility services**. The lifetime maximums that apply to infertility services apply differently than other lifetime maximums under the plan.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment *(GR-9N-S-10-055-01)*		
Outpatient In Vitro Fertilization	**Deductibles** and/or **Copays** are the same as required for any other **illness**. The Coinsurance is the same that is payable for any other illness.	**Deductibles** and/or **Copays** are the same as required for any other **illness**. The Coinsurance is the same that is payable for any other illness.
Maximum Benefit per lifetime:	$15,000	$15,000

Preventive Health Care Services Expenses

The charges below are included as Covered Expenses even though they are not incurred in connection with an **injury** or **illness**. They are included only for a dependent child under 19 years of age.

- A review and written record of the child's complete medical history.
- Taking measurements and blood pressure.
- Developmental and behavioral assessment.
- Vision and hearing screening.
- Other diagnostic screening tests including:
  - One series of hereditary and metabolic tests performed at birth;
  - Urinalysis, tuberculin test, blood tests such as hematocrit and hemoglobin tests;
  - Tests for phenylketonuria, hypothyroidism, galactosemia, sickle-cell anemia, and other genetic disorders of metabolism.
- Immunizations for infectious disease.
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered Medical Expenses will only include charges incurred for Preventive Health Care Services performed at birth and at approximately each of the following ages:

2	weeks	18	months	10	years
2	months	2	years	12	years
4	months	3	years	14	years
6	months	4	years	16	years
9	months	5	years	18	years
12	months	6	years		
15	months	8	years		

Expenses incurred for vaccines and immunizations for infectious disease will not be subject to a Calendar Year deductible; per visit copay/deductible; coinsurance; or maximum benefit per Calendar Year.

Not covered are charges incurred:

- For services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer;
- For services which are for diagnosis or treatment of a suspected or identified injury or disease;
- for services not performed by a physician or under his or her direct supervision;
- For medicines, drugs, appliances, equipment or supplies;
- For dental exams;
- For exams related in any way to employment;

- For pre-marital exams; or
- To the extent they are in excess of the Medicaid reimbursement level in the State of Arkansas for the same service or supply.

Routine Mammogram Screenings **Eligible health services** include, but are not limited to, charges incurred for routine mammogram screenings as follows:

- 1 baseline mammogram for a woman age 35-40
- 1 mammogram per Calendar Year for a woman age 40 or older
- Upon recommendation of a woman's **physician**, regardless of age, when the woman or her mother or sister has a history of breast cancer, positive genetic testing, or other risk factors
- 1 comprehensive ultrasound screening of an entire breast(s) if a mammogram demonstrates heterogeneously dense or extremely dense breast tissue.

Benefits will be paid on the same basis any other applicable covered expense under this plan.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 90 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network mail order pharmacy**. **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**.

Corrective Surgery and Treatment of Craniofacial Anomaly

Covered expenses include charges made for corrective surgery and related medical care including dental, vision and the use of at least one hearing aid for insured's of any age diagnosed as having craniofacial anomaly.

Corrective surgery means the use of surgery to alter the form and function of the cranial tissues due to a congenital or acquired musculoskeletal disorder. Craniofacial anomaly means a congenital or acquired musculoskeletal disorder that primarily affects the cranial facial tissue.

Denial or any limitation of coverage based on lack of medical necessity to improve a functional impairment would be referred for an external review under Arkansas External Review regulation.

The expenses will be payable in accordance with the service rendered and location of where the expense was incurred.

Medical Foods and Low Protein Modified Foods *(GR-9N 11-156 01-AR)*

Covered expenses include charges incurred by a covered person; for non-prescription enteral formulas for which a physician has issued a written order; and are for the treatment of malabsorption caused by:

Crohn's Disease;
ulcerative colitis;
gastroesophageal reflux;
gastrointestinal motility;
chronic intestinal pseudoobstruction; and
inherited diseases of amino acids and organic acids.

Covered Expenses for inherited diseases of: amino acids; and organic acids; will also include food products modified to be low protein.

Continuation of Coverage for Your Former Spouse

If health coverage for the your dependent spouse would terminate due to divorce or annulment, the former spouse may continue to be covered (except for Dental Insurance). Your former spouse must have been covered for the health coverage as your dependent for at least 3 months in a row.

The person has to request continuation within 10 days of the date of the divorce or annulment.

Premium payments must be continued. Coverage will end on the earlier of the following:

- The end of 120 days after the date of the divorce or annulment.
- The date you are no longer covered under this Plan.
- The date the person becomes eligible for like coverage, including coverage for any preexisting condition, under any other group plan.
- The date dependent coverage ceases under this Plan for your Eligible Class.
- The end of the period for which contributions have been made.

Continuing Coverage after Termination of Employment

If your coverage terminates for any reason you may continue any health coverage (except Dental Insurance) in force for you and your dependents but, only if the coverage has been in force for you for at least 3 months in a row.

You have to make request in writing for this continuation. It must be done within 10 days of the date your coverage would otherwise stop. Premium payments must be made.

Coverage will stop on the earlier of:

- The end of the 120 day period which starts on the date coverage would otherwise end.
- The date you are eligible for like coverage, including coverage for any preexisting condition under any other group plan.
- The date you fail to make the required contributions.
- The date health coverage discontinues as to employees of your former Employer.

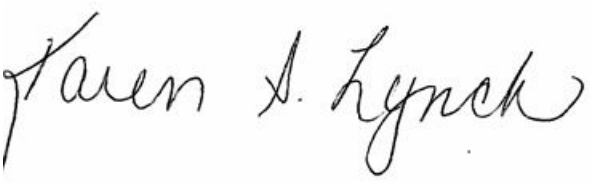
Coverage for a dependent will end when the dependent:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the group contract.

When Extended Health Coverage Ends
Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.
- If you are confined in a hospital, the date you are discharged from the hospital.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)



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

Amendment: Arkansas Medical ET
Issue Date: October 25, 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 Colorado. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Cleft Lip or Palate Treatment *(GR-9N 11-155 02 CO)*

Treatment of Cleft Lip or Palate Cleft Lip/Palate of a Dependent Child
Covered expenses for treatment given to a dependent child for a congenital cleft lip or cleft palate are payable on the same basis as any other **illness**. This includes treatment for any other condition related to or developed as a result of the cleft lip or palate. These covered expenses include:

- Oral surgery and facial surgery. This includes pre-operative and post-operative care performed by a Physician.
- Oral prosthesis treatment (obturators and orthotic devices).
- First installation of partial or full removable dentures or of fixed bridgework, if dentures are not professionally adequate.
- Replacement of dentures or fixed bridgework when required as a result of structural changes in the mouth or jaw due to growth.
- Cleft orthodontic therapy.
- Diagnostic services of a physician to find out if and to what extent the child's ability to speak or hear has been lost or impaired.
- Habilitative speech therapy rendered by a Physician that is expected to overcome congenital or early acquired handicaps as well as to restore or improve the child's ability to speak.

An audiologist or speech therapist who is legally qualified will be deemed a **Physician** for the purposes of this section.

Limitations
Not covered under this benefit are charges for:

- Oral prosthesis, dentures or bridgework ordered before the child becomes covered, or ordered while covered but installed or delivered more than 60 days after termination of coverage.
- Services given to treat delays of speech development unless such delays are shown to be 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 such aids.
- Augumentive (assistive) Communication Systems and training in the use of such systems.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Cleft Lip or Palate Treatment For Dependent Children *(GR-9N S 11-95 04 CO)*	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Child Health Supervision Services (Applicable to Dependent children under age 13) *(GR-9N 11-005-01 CO)*
Covered expenses include **physician**-delivered or **physician**-supervised services for a dependent child under 13 years of age even though they are not incurred in connection with an injury or **illness**.

The following charges will be payable when the service is delivered at the intervals and scope show in the Table below:

- A review and written record of the child's complete medical history.
- Physical examination.
- Developmental and behavioral assessment.
- Anticipatory guidance and education.
- Immunizations including diphtheria, haemophilus influenza type B, hepatitus B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization as recommended by the American Academy of Pediatrics.
- Laboratory tests.

All of the above will be in keeping with prevailing medical standards.

Only charges of one **physician** for Child Health Supervision Services performed at birth will be payable and then at approximately each of the following ages:

2 months	15 months	5 years
4 months	18 months	6 years
6 months	2 years	8 years
9 months	3 years	10 years
12 months	4 years	12 years

Not covered are charges incurred for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are covered to any extent under any other group plan sponsored by your Employer;
- Services which are for diagnosis or treatment of a suspected or identified injury or **illness**;
- Services not performed by a **physician** or under his or her direct supervision;
- Medicines, drugs, appliances, equipment, or supplies; or
- Dental exams.

Routine Cancer Screenings *(GR-9N 11-005-03 CO)*
Covered expenses include charges incurred for routine cancer screening as follows:

- 1 baseline mammogram for a woman 35-40 years of age;
- 1 mammogram every calendar year for women 40 years of age or older;
- 1 cervical cancer immunization for women, up to the age limitations recommended by the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services; and
- Prostate specific antigen (PSA) test and digital rectal exam for covered males age 40 and older.

Routine Cancer Screening Outpatient *(GR-9N S-10-016 05 NG CA)*	100% per visit No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible** .

Colorectal Cancer Treatment

Covered expenses include charges for the treatment for the early detection of colorectal cancer and adenomatous polyps for those who are asymptomatic average risk adults who are 50 years of age or older or if you are at a high risk for colorectal cancer including those who have a family medical history of colorectal cancer, a prior occurrence of cancer or precursor neoplastic polyps, a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, ulcerative colitis or other predisposing factors as determined by a physician.

Covered expenses shall include the following tests as determined by a physician that detects adenomatous polyps or colorectal cancer modalities that are currently included in an "A Recommendation" or a "B Recommendation" by the U.S. Preventive Services task force or any successor organization sponsored by the Agency for Health Care Research and Quality, the Health Services Research Arm of the Federal Department of Health and Human Services.

For purposes of this section, an "A Recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:

a) found good evidence that the preventive health care service improves important health outcomes; and
b) concluded that the benefits of the preventive health care service substantially outweigh its harm.

A "B Recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:

a) found at least fair evidence that the preventive health care service improves important health outcomes; and
b) concluded that the benefits of the preventive health care service outweigh its harm.

Covered expenses shall not be subject to the **deductible**, if applicable.

Physician Services *(GR 9N 11-20 02 CO)*

Physician Visits

Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician**'s office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment,
- Allergy testing and allergy injections; and
- Services appropriately provided via telephone (also known as Telemedicine) if you reside in a county of 150,000 residents

Contraception Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Autism Spectrum Disorders *(GR-9N 11-171 02 CO)*

Covered expenses include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis and treatment (including behavioral therapy and Applied Behavioral Analysis) of Autism Spectrum Disorder when ordered by a **physician** as part of a Treatment Plan; and

  - The covered child is diagnosed with Autism Spectrum Disorder; and
- The **covered expenses** are incurred prior to attainment of age 19.

Applied Behavioral Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association:

- Autistic Disorder;
- Asperger's Syndrome; and
- Atypical autism as a diagnosis with Pervasive Developmental Disorder - Not Otherwise Specified.

Treatment for Autism Spectrum Disorders shall include habilitative or rehabilitative care, including, but not limited to:

- Occupational therapy;
- Physical therapy;
- Speech therapy; or
- Any combination of these therapies.

Clinical Trials

A clinical trial is an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

Routine patient care costs are a covered expense if:

(I) your treating physician, who is providing covered health care services to you recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit;

(II) the clinical trial or study is approved under the September 19, 2000 Medical National Coverage Decision Regarding Clinical Trials, as amended;

(III) your care is provided by a certified, registered or licensed health care provider practicing with the scope of their practice and the facility and personnel providing the treatment have experience and training to provide the treatment in a competent manner;

(IV) prior to participation in a clinical trial or study, you signed a statement of consent indicating that you were informed of the procedure to be undertaken, alternative methods of treatment and the general nature and extent of the risks associated with participation in the clinical trial or study, the Covered Expenses will be consistent with the coverage provided by the Group Policy and this Certificate; and

(V) you suffer from a condition that is disabling, progressive or life-threatening.

Routine care costs include:

- all items and services that a benefit under the Group Policy and this Certificate would be covered if you were not involved in either the experimental or the control arms of a clinical trial; except the investigation item or service, itself;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- items and services customarily provided by the research sponsors free of charge for any enrollee in the trial;
- routine costs in clinical trials that include items and services that are typically provided absent a clinical trial;
- items or services required solely for the provision of the investigation items or services, the clinically appropriate monitoring of the effects of the item or service or the prevention of complications; and
- items or services needed for reasonable and necessary care arising from the provision of an investigation item or service, including the diagnosis or treatment of complications.

Limitations

Not included under this clinical trial benefit are charges incurred for:

(I) any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical or medical industry;

(II) any drug or device that is paid for by the manufacturer, distributor or provider of the drug or device;

(III) extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing and other expenses that a participant or person accompanying the participant may incur;

(IV) an item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;

(V) costs for the management or research relating to the clinical trial or study; or

(VI) health care services, that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Group Policy and this Certificate.

Inherited Enzymatic Disorder. Care and treatment of inherited enzymatic disorders shall include, to the extent **medically necessary**, medical foods for home use for which a physician who is a **network provider** has issued a written, oral or electronic prescription. Inherited enzymatic disorders caused by single gene defects involved in the

metabolism of amino, organic, and fatty acids shall include, but not be limited to, the following diagnosed conditions: Phenylketonuria, maternal phenylketonuria, maple syrup urine disease; tyrosinemia, homocystinuria; histidinemia, urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic academia and propionic academia.

There is no age limit on benefits for the above inherited enzymatic disorders; except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is 21 years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is 35 years of age.

"Medical foods" means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by singe gene defects involved in the metabolism of amino, organic, and fatty acids for which medically standard methods of diagnosis, treatment and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered internally either via tube or oral route under the direction of a **physician** who is a **network provider**. Coverage shall only be available through a **network pharmacy**.

Hospital *(GR-9N 34-040-01 CO)*

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations; and
- Is currently licensed or certified by the Colorado Department of Health and Environment.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

Experimental or Investigational *(GR-9N-34-025-09 CO)*

Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the U.S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or

- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

It also includes the written informed consent used by the treating facility or by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
  - treatment

  that states that it is **experimental or investigational**, or for research purposes.

Continuing Coverage *(GR-9N 31-015-01 CO)*

If your coverage would terminate for any reason except:

- Health Expense Coverage discontinues as to your eligible class; or
- You fail to make the required contributions;
- You become eligible for Medicare;

you may continue any health coverage (except Dental, Vision and Prescription Drug Expense Coverage) then in force for you and your dependents; but, only if you have been covered under this Plan or under this Plan and any prior plan for at least 6 months in a row.

You have to make request in writing for this continuation. It must be done within 31 days of the date your coverage would otherwise stop. Premium payments must be made.

Coverage will stop on the earlier of:

- The end of the 180 day period which starts on the date coverage would otherwise end.
- The date you are employed by any employer.
- The date you fail to make the required contributions.
- The date health coverage discontinues as to employees of your former eligible class.
- The date you became eligible for like group coverage. If you have a preexisting condition or any other condition covered under this Plan but for which coverage is not available under the like coverage, this will not apply unless and until coverage is available under the like group coverage.
- Coverage for a dependent will end earlier when the dependent ceases to be a defined dependent.

Important Note
If any coverage being continued ceases, you may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

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

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

Pregnancy Related Expenses *(GR 9N 11-100 01 CT)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

Covered expenses include charges for pregnancy and childbirth expenses at the same level of any other applicable illness or injury. For inpatient care of the mother and newborn child, the plan will pay for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.

Any decision to shorten such minimum coverages shall be made by the attending physician**;** in consultation with the mother. In such cases; covered services shall include: home visits; parent education; and assistance and training in breast or bottle-feeding.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Understanding Precertification *(GR-9N 08-060-01-CT)*

Precertification

Certain services, such as inpatient **stays**, certain tests, procedures and **outpatient surgery** require **precertification** by **Aetna**. **Precertification** is a process that helps you and your **physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows **Aetna** to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from **Aetna** for any services or supplies on the **precertification** list below. If you do not **precertify**, your benefits will be reduced by $500 or 50% of the cost of the expense whichever is less, or the plan may not pay any of the expenses if the service or supply is not medically necessary. The list of services requiring **precertification** follows on the next page.

Important Note
Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

The Precertification Process

Prior to being **hospitalized** or receiving certain other medical services or supplies there are certain **precertification** procedures that must be followed.

You are responsible for obtaining **precertification**. You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission or medical services and expenses prior to receiving any of the services or supplies that require **precertification** pursuant to this Booklet-Certificate in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call **Aetna** at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your **physician** or the facility will need to call and request **precertification** at least 14 days before the date you are scheduled to be admitted.
For an **emergency** outpatient **medical condition**:	You or your **physician** should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an **emergency admission**:	You, your **physician** or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an **urgent admission**:	You, your **physician** or the facility will need to call before you are scheduled to be admitted. An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an **illness**; the diagnosis of an **illness**; or an **injury**.
For outpatient non-emergency medical services requiring **precertification**:	You or your **physician** must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.
For prenatal care and delivery:	As soon as possible after the attending **physician** confirms pregnancy and again within 48 hours of the birth or as soon thereafter as possible. No benefit reduction will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.

Aetna will provide a written notification to you and your **physician** of the **precertification** decision. If your **precertified** expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, **Aetna** will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be certified. You, your **physician**, or the facility will need to call **Aetna** at the number on your ID card as soon as

reasonably possible, but no later than the final authorized day. **Aetna** will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna's** decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the Appeals Amendment included with this Booklet-Certificate.

How Failure to Precertify Affects Your Benefits *(GR-9N 08-070-01-CT)*
A **precertification** benefit reduction will be applied to the benefits paid if you fail to obtain a required **precertification** prior to incurring medical expenses. This means **Aetna** will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary **precertification** from **Aetna** prior to receiving services from an **out-of-network provider**. Your provider may **precertify** your treatment for you; however you should verify with **Aetna** prior to the procedure, that the provider has obtained **precertification** from **Aetna**. If your treatment is not **precertified** by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered. If your treatment is not **precertified** by you or your **provider**, the benefit payable will be reduced by $500 or 50% of the expense whichever is less, or your expenses may not be covered if the service or supply is not medically necessary.

The Booklet-Certificate contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- The benefit payable will be reduced by $500 or 50% of the expense whichever is less, or your expenses may not be covered if the service or supply is not medically necessary.

Subrogation and Right of Reimbursement

The sub-section entitled "Subrogation and Right of Reimbursement", if included in the General Provisions part of your Booklet-Certificate, has been removed and does not apply to your plan of benefits.

Coordination of Benefits
Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or **recognized charges**, any amount in excess of the highest of the reasonable or **recognized charges** for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.

4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Plans covering a person are high deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan's deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or **recognized charges** and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the policy that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

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

Amendment: Connecticut 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 Indiana. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Notice to Policyholders and Certificate Holders

Questions regarding your policy or coverage should be directed to:

Aetna Life Insurance Company
Contact Number: See your Member ID Card.

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone, or email:

Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 baseline mammogram for covered females who are age 35 but less than age 40, or one mammogram every 12 months for covered females less than age 40 who are at risk;
- 1 Pap smear every 12 months;
- 1 gynecological exam every 12 months;
- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.

The following tests are **covered expenses** if you are age 50 and older, or less than age 50 and at high risk when recommended by your **physician**:

- 1 Sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk); *or*
- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer.

Diabetic Equipment, Supplies and Education *(GR-9N-11-135-01 IN)*

`**Covered expenses** include charges for the following services, supplies, equipment, as ordered by a **physician**, and training for the treatment of insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy:

- Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

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

Amendment: Indiana 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 Kentucky. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Routine Mammograms

Covered expenses include charges incurred for routine cancer screening as follows:

- One screening mammogram, for a person age 35 but less than 40.
- One mammogram every two years for a person age 40 but less than 50.
- One mammogram each Calendar Year, for a person age 50 or over.
- A mammogram for women who have been diagnosed with breast disease, upon referral by a health care practitioner acting within the scope of the practitioner's license.

Diabetic Equipment and Self-Management Education Expenses

(GR-9N 11-135-01 AK)

Covered expenses include charges for the following expenses incurred in connection with the treatment of diabetes (including insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes):

- Equipment;
- Supplies;
- Outpatient self-management training and education (including medical nutrition therapy);
- Medications.

The treatment must be prescribed by a **physician**.

Outpatient self management education must be provided by a certified, registered or licensed provider with expertise in diabetes.

Charges incurred for the following are not included:

- a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
- a general program not just for diabetics; or
- a program made up of services not generally accepted as necessary for the management of diabetes.

Charges made for the following are not covered:

- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care while in the custody of a governmental authority; except if the covered person is incarcerated in a local or regional jail prior to a conviction of a felony.

Coordination of Benefits - What Happens When There is More Than One Health Plan

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to This Plan when you or your covered dependent has health coverage under more than one Plan. "Plan" and "This Plan" are defined herein. If any provision of this section is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this section shall continue in full force and effect. The Order of Benefit Determination Rules below determines which Plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense. If you are covered by more than 1 health benefit Plan, you should file all your claims with each Plan.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
- **Medicare** or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts are not Plans.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the policy that provides benefits for health care expenses.

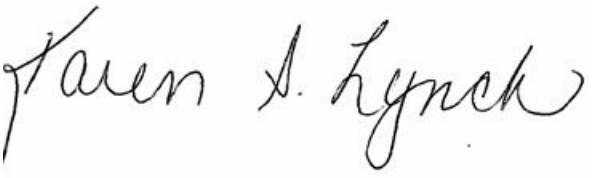
Non-Occupational Injury

A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

An injury will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **injury** under such law.



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

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

Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices;
- Provides medical services which are within the scope of his or her license or certificate.
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, drug abuse, or a **mental disorder**; and
- Is not you or related to you.

This also includes a licensed health professional who:

- Under applicable insurance law, are considered a "**physician**" for purposes of this coverage and;
- Are properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Have the medical training and clinical expertise suitable to treat your condition;
- Specialize in behavioral health, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, drug abuse, or a **mental disorder**; and
- Are not you or related to you.

1. The Habilitative services provision contained in the Other Services section of the Certificate is deleted and replaced in its entirety with the following:

Habilitation therapy services

Habilitation therapy services are services and devices, including occupational therapy, physical therapy and speech therapy, that help a child keep, learn, or improve skills and functioning for daily living.

Covered expenses include habilitation therapy services for covered persons until the end of the month in which they

turn 19 years of age, and that a **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 the covered person's **Physician**, that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in the covered person's home, if homebound

2. The Accident and Health Insurance Claims portion of the Reporting of Claims provision contained in the General Provisions section of your Certificate is deleted and replaced in its entirety with the following:

Accident and Health Insurance Claims

In addition to the above, a claim must be submitted to **Aetna** in writing within 1 year of the date of the loss. All claims must give proof of the nature and extent of the loss. Your employer has claim forms or you can request a claim form from **Aetna**. If you request and do not receive a claim from Aetna within 15 days after your request, you will have complied with the reporting of a claim requirement if you submit, within the time period noted, written proof of the occurrence, character, and extent of the loss for which the claim is made.

Aetna will not invalidate or reduce your claim if it is not reasonably possible for you to meet the deadline for filing your claim and notice was given as soon as reasonably possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

All other terms and conditions of the group policy shall remain in full force and effect except as amended herein.

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

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

Massachusetts Mental Health Parity Laws and the Federal Mental Health Parity and Addiction Equity Act (MHPAEA)

This notice is sent to give you information about your benefits for mental health and substance use disorder services. Under both Massachusetts laws and federal laws, benefits for mental health services and substance use disorder services must be comparable to benefits for medical/surgical services. This means that copays, coinsurance and deductibles, for mental health and substance use disorder services must be at the same level as those for medical/surgical services. Also, our review and authorization of mental health or substance use disorder services must be handled in a way that is comparable to the review and authorization of medical/surgical services.

If we make a decision to deny or reduce authorization of a service, we will send you a letter explaining the reason for the denial or reduction. We will send you or your provider a copy of the criteria used to make this decision, at your request.

If you think that we is are not handling your benefits for mental health and substance use disorder services in the same way as for medical/surgical services, you may file a complaint with the Division of Insurance (DOI) Consumer Services Section.

You may file a written complaint using the DOI's Insurance Complaint Form. You may request the form by phone or by mail or find it on the DOI's webpage at:

http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html

You may also submit a complaint by phone by calling 877-563-4467 or 617-521-7794.
If you submit a complaint by phone, you must follow up in writing and include your name and address, the nature of your complaint and your signature authorizing the release of any information.

Filing a written complaint with the DOI is not the same as filing an appeal under your plan. You must also file an appeal with us in order to have a denial or reduction in coverage of a service reviewed. This may be necessary to protect your right to continued coverage of treatment while you wait for an appeal decision. Follow the appeal procedures outlined in your plan for more information about filing an appeal.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: TW Ventures Inc.
Group Policy No.: GP-861495-C
Rider: Massachusetts ET Medical
Issue Date: June 19, 2019
Effective Date: August 1, 2019

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Massachusetts. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Massachusetts, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Physician Profiling

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

Interpreter and Translation Services

You may contact Member Services at the toll-free telephone number listed on your I.D. card to receive information on interpreter and translation services related to administrative procedures. A TDD# for the hearing impaired is also available.

French
Services d'interprétation et de traduction
Vous pouvez contacter les services aux membres au numéro de téléphone sans frais indiqué sur votre carte d'identification pour recevoir de l'information sur les services d'interprétation et de traduction se rapportant aux procédures administratives. Les professionnels du service à la clientèle Aetna ont accès à des services de traduction par le biais des services linguistiques téléphoniques de AT&T. Un numéro de téléphone ATME est aussi disponible pour les malentendants.

Greek

Υπηρεσιες Μεταφρασεως

Για να λαβετε πληροφοριες οσον αφορα των υπηρεσιων μας μεταφρασεως σχετικα με την διαδικασια διοικητικη, μπορειτε να ερχοσαστε σε επαφη με την Υπηρεσια για τα Μελη στον αριθμο (χρωις διοδια) που βρισκεται επανω στην εξακριβωση σας ταυτοτητας. Οι επαγγελματικοι υπαλληλοι (του τμηματος της Αετνα το οποιο ανασχολειται με τους πελατες) μπορουν να χρησιμοποιουν την μεταφραστικη υπηρεσια της εταιρειας AT&T.

Italian

Servizi di traduzione e di interpretariato

Per ottenere informazioni sui servizi di traduzione e interpretariato connessi a procedure amministrative, potete rivolgervi al Servizio Membri chiamando il numero di linea verde indicato sulla vostra carta di ID. I professionisti del servizio clientela della Aetna hanno accesso ai servizio di traduzione della linea linguistica della AT&T. È anche disponibile un No TDD per i deboli di udito.

Portuguese

Serviços de Intérprete e de Tradução

Você poderá entrar em contato com os Serviços dos Associados ao telefone livre de tarifa indicado no seu cartão de identificação para obter informações sobre serviços de intérprete e de tradução com relação aos procedimentos administrativos. Os profissionais dos serviços aos clientes têm acesso aos serviços de tradução através da linha de idiomas da AT&T. Existe também uma linha TDD para quem tem dilficuldades com a audição.

Russian

Услуги по устному и письменному переводу

Чтобы получить информацию о предоставляемых услугах устного и письменного перевода, вы можете обращаться в отдел обслуживания членов программы по бесплатному номеру телефона, указанному на вашей членской карточке. Сотрудники Aetna по обслуживанию клиентов имеют доступ к переводческим услугами по языковой линии AT&T. Имеется также устройство связи для лиц с дефектами слуха (TDD).

Spanish

Servicio de Intérprete y Traducción

Usted puede ponerse en contacto con Servicios a Miembros, al número de teléfono gratis que aparece en su tarjeta de identificación para recibir información sobre servicios de intérprete y traducción relativo a los procedimientos administrativos. Los profesionales de servicio a clientes de Aetna tienen acceso a los servicios de traducción por medio de la linea de idiomas de AT&T. Además hay un número de TDD para las personas con impedimento de audición.

Haitian-Creole

Sèvis intèprèt ak tradiktè

Ou kapab pran kontak avèk Sèvis pou manm-yo si ou rele nimewo telefòn gratis ki sou kat I.D.-ou-a (idantifikasyon) pou ou jwenn ransèyman sou sèvis intèprèt ak tradiktè konsènan pwosedi administratif. Pwofesyonnèl nan sèvis kliyan "Aetna" gen mwayden jwenn sèvis tradiksyon nan "AT&T language line" (sèvis lang AT&T). Yon nimewo TDD disponnib tou pou moun ki pa tande byen.

Lao

ການບໍລິການນາຍພາສາແລະການແປພາສາ

ທ່ານສາມາດຕິດຕໍ່ຜແນກບໍລິການສະມາຊິກໄດ້ ໂດຍໃຊ້ເບີໂທບໍລິການຢູ່ທີ່ປາກົດເທິງບັດປະຈຳ ໂອສະມາຊິກຂອງທ່ານ ເພື່ອໄດ້ຮັບລາຍລະອຽດຕ່າງໆ ກ່ຽວກັບການບໍລິການນາຍພາສາແລະ ລິການແປພາສາທີ່ກ່ຽວຂ້ອງກັບການດຳເນີນການທາງດ້ານການບໍລິຫານ. ພະນັກງານຂອງ ແຜນກບໍລິການລູກຄ້າບອງບໍລິສັດເອັດນາ (Aetna) ສາມາດຕິດຕໍ່ກັບການບໍລິການທາງດ້ານ ານແປພາສາໄດ້ ໂດຍຜ່ານສາຍແປພາສາ (Language Line) ຂອງບໍລິສັດ AT&T. ຍັງ ໃຊ້ເບີໂທຂອງລະບົບ TDD ໄວ້ສຳຫລັບຜູ້ທີ່ໄດ້ຍິງສຽງບໍ່ຄ່ອຍໃຊ້ໃນການຕິດຕໍ່ອີກດ້ວຍ.

Cambodian

ៈសេវាកម្មផ្នែកបកប្រែភាសា

អ្នកអាចទាក់ទងសេវាកម្មសមាជិក តាមរយៈលេខ ឥតគិតថ្លៃ ដែលចុះនៅលើកាតសំគាល់របស់ អ្នក ដើម្បីទទួលពត៌មាន អំពី សេវាកម្មផ្នែកបកប្រែភាសា ដែលទាក់ទងនឹងវិធីចាត់ចែងការ ។ អ្នកជំនាញការផ្នែកសេវាកម្មនៃអតិថិជនរបស់ Aetna **មានមធ្យោបាយរកសេវាកម្មបកប្រែ តាមរយៈខ្សែទូរស័ព្ទភាសា** AT&T **។ លេខ** TDD# **សំរាប់មនុស្សគថ្លង់ ក៏មានផងដែរ ។**

Chinese

口譯及筆譯服務

您可以通過撥打列在您會員卡上的免費電話號碼與會員服務處聯絡，以便獲取有關實施程序的口譯及筆譯服務的資訊。**Aetna**的專業用戶服務人員使用**AT&T**語言專線 **(AT&T Language Line)** 的翻譯服務。還有一個專門為聽力有障礙的用戶提供的**TDD**號碼。

Arabic

خدمات الترجمة الشفهية والكتابية

تستطيع الاتصال بدائرة خدمات الأعضاء على رقم الهاتف المجاني المدرج على بطاقة هويتك للحصول على معلومات حول خدمات الترجمة الشفهية والكتابية المتعلقة بالإجراءات الإدارية. فموظفو دائرة خدمة الزبائن لدى شركة Aetna يستطيعون تلقي خدمات الترجمة عن طريق خط اللغات لشركة AT&T. ويتوفر للأصماء أيضاً رقم جهاز إتصالات الأصماء (TDD).

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

Which Plan Pays First *(GR-9N 33-010 03 MA)*

When two or more **plans** pay benefits, the rules for determining the order of payment are as follows**:**

- The **primary plan** pays or provides its benefits as if the **secondary plan** or **plans** did not exist.
- A **plan** that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage

shall be excess to any other parts of the **plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.

- A **plan** may consider the benefits paid or provided by another **plan** in determining its benefits only when it is secondary to that other **plan**.
- The first of the following rules that describes which **plan** pays its benefits before another **plan** is the rule to use:

1. Medical Payments Coverage and PIP Coverage in Motor Vehicle Insurance Policies.
   If a person is covered under a motor vehicle policy and incurs expenses or requires services as a result of an accident with a motor vehicle:

   A. Personal Injury Protection (PIP) is the **primary plan** for the first $2,000 of expenses. After that, **plans** will coordinate benefits in accordance with these coordination of benefits provisions.

      PIP refers to the personal injury protection coverage included in a motor vehicle liability insurance policy.

   B. MedPay means medical coverage that can be purchased in connection with a motor vehicle liability policy. MedPay will always be secondary to and in excess of any other **plan** or PIP.

2. Non-Dependent or Dependent. The **plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the **plan** that covers the person as a dependent is secondary. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the **plan** covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **plans** is reversed so that the **plan** covering the person as an employee, member, subscriber or retiree is secondary and the other **plan** is primary.

3. Child Covered Under More Than One **Plan**. The order of benefits when a child is covered by more than one **plan** is:

   A. The **primary plan** is the **plan** of the parent whose birthday is earlier in the year if:

      i. The parents are married or living together whether or not married;

      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the **plan** that covered either of the parents longer is primary.

   B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the **plan** of that parent has actual knowledge of those terms, that **plan** is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the **primary plan**.

   - If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage , the order of benefits is:

     - The **plan** of the **custodial parent**;
     - The **plan** of the spouse of the **custodial parent**;
     - The **plan** of the non**custodial parent**; and then
     - The **plan** of the spouse of the non-**custodial parent**.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

4. Active Employee or Retired or Laid off Employee. The **plan** that covers a person as an employee who is neither laid off nor retired, or as a dependent of an active employee, is the **primary plan**. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the **secondary plan**. If the other **plan** does not have this rule, and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another **plan**, the **plan** covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other **plan** does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

6. Longer or Shorter Length of Coverage. The **plan** that covered the person as an employee, member, or subscriber longer is primary.

7. If the preceding rules do not determine the **primary plan**, the allowable expenses shall be shared equally between the **plans** meeting the definition of **plan** under this provision. In addition, **This Plan** will not pay more than it would have paid had it been primary.]

(GR-9N 29-010-01)
An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship, or whose parent is your child and is covered as a dependent under the plan.

When You Receive a Qualified Child Support Order *(GR-9N 29-015-01 MA)*
A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

If you fail to make an application to obtain coverage of a child, **Aetna** shall enroll such child upon application by such child's other parent, by the division of medical assistance or upon receipt of a national medical support notice from the IVD agency.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Long-term Antibiotic Therapy for Lyme Disease

Covered expenses include long-term antibiotic therapy for Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patients' symptoms, diagnostic test results or response to treatment. Further, an experimental drug shall be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration; provided, however, that a drug, including an experimental drug, shall be covered for an off-label use in the treatment of Lyme disease if the drug has been approved by the United States Food and Drug Administration.

Prosthetic Devices *(GR-9N 11-110-01 MA)*

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators;
- A durable brace that is custom made for and fitted for you;
- A scalp hair prosthesis (wig) for hair loss due to treatment of any form of cancer or leukemia;
- Therapeutic/molded shoes and shoe inserts required for the treatment of or to prevent complications of diabetes.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items or
- any item listed in the *Exclusions* section.

Gatekeeper PPO Medical Plan *(GR9N 11 80 01 MA)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Any coinsurance requirement for artificial limb devices to replace, in whole or in part, an arm or leg will not exceed 20%, unless such coinsurance applies to all covered benefits. With respect to Out of Network charges, any coinsurance will not exceed 40% of the cost unless such coinsurance applies to all covered benefits under the plan.		
Scalp Hair Prosthesis for Cancer or Leukemia Patients *(GR-9N-S10-95-01 MA)*	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Benefit per Calendar Year	$350	$350

Cleft Lip or Palate Treatment

Treatment of Cleft Lip or Palate of Dependent Children Under Age 18

Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Medical, dental, oral surgery and facial surgery, surgical management including pre- and post-operative care provided by oral and plastic surgeons;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Preventative and restorative dentistry to ensure good health;
- Adequate dental structures for orthodontic treatment or prosthetic management therapy;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiology;
- Nutrition services;

- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

If such services are prescribed by the treating physician or surgeon and such physician or surgeon certifies that such services are medically necessary and consequent to the treatment of the cleft lip, cleft palate or both.

Payment for dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate will not be covered under this section.

Limitations
Unless specified above, not covered under this benefit are:

- 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;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

Hearing Aids Expense

Covered expenses include charges incurred by a covered person for the cost of one hearing aid per hearing impaired ear every 36 months upon written statement from the covered person's treating physician that the hearing aid(s) are necessary regardless of etiology.

Covered expenses also include related services prescribed by a licensed audiologist or hearing instrument specialist, including the initial hearing aid evaluation, fitting and adjustments and supplies, including ear molds.

Coverage is provided under the same terms and conditions as for any other condition.

Hearing Aids *(GR-9N-S-10-80-05 MA)*	xxx% per item after Calendar Year **deductible**	xxx% per item after Calendar Year **deductible**

Clinical Trial Expenses *(GR-9N 11-210-01 MA)*

This Plan will pay for **medically necessary** and routine patient care, **physician**, and facility charges you incur when enrolled in a qualified clinical trial study.

A "qualified clinical trial" means a patient research study that meets the following criteria:

- it must be intended to treat cancer; and
- it must be peer reviewed and approved by one of the following:
  - one of the United States Institutes of Health;
  - a center or cooperative group of the National Institutes of Health;
  - a qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
  - the Food and Drug Administration (FDA) pursuant to an investigational new drug exemption;
  - the Department of Defense;
  - the Department of Veterans Affairs; or
- with respect to a Phase II, III and IV clinical trial
  - a qualified institutional review board; and
  - it must be provided by a provider of health care which has the experience and training to provide the treatment in a capable manner; and

- with respect to Phase I clinical trials
  - it must be provided by an academic medical center or affiliated facility, and the providers conducting the trial shall have staff privileges at the academic medical center; and
  - you meet the patient selection criteria for participation in the qualified clinical trial; and
  - you must have signed, prior to participation in the qualified clinical trial, a statement of consent.
- available clinical or pre-clinical data provide a reasonable expectation that participation is likely to be beneficial to you; and
- it does not duplicate existing studies; and
- it must have a therapeutic intent and must assess the effect of the intervention.

Charges for **covered expenses** you incur for the treatment provided in the clinical trial are payable on the same basis as any disease or illness covered under this plan.

Any care provided in the clinical trial must be for services that are considered **covered expenses** under this plan. They must be consistent with all of the terms and conditions of this plan including but not limited to:

- Aetna's Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Clinical trial expenses are subject to all of the terms; conditions; provisions; limitations; and exclusions of this plan including, but not limited to: precertification and referral requirements.

Not covered under this plan are:

- any drug or device that is approved by the FDA, even when the off-label use of the drug or device has not been approved by the FDA for that indication, if the drug or device is paid for by the manufacturer, distributor, or provider of the drug or device; and
- any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry; and
- costs of data collection and record-keeping that would not be required but for the clinical trial; and
- any expenses for the management of research; and
- any expenses related to participation in the clinical trial; and
- services and supplies provided "free of charge" by the trial sponsor to the covered person.

Psychiatric Physician

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, drug abuse, **mental disorders**, or **serious mental illnesses**.

For Massachusetts residents, to the extent required by law, this also includes the following licensed providers:

- Psychologist;
- Independent Clinical Social Worker;
- Mental Health Counselor;
- Nurse Mental Health Clinical Specialist; and
- Marriage and Family Therapist.

Telemedicine *(GR-9N-S-11-020-01)*

Covered expenses include the application of telemedicine for covered services provided by a **physician** acting within the scope of their license as a method of delivery of medical care by which an individual shall receive medical services from a health care provider without in-person contact with the provider. Coverage is provided for only those

services that are **medically necessary** and subject to the terms and conditions of the covered person's policy. Coverage for health care services under this provision will be consistent with coverage for health care services provided through an in-person consultation.

Telemedicine means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine or e-mail.

Aetna may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by **Aetna**.

The deductible, copayment or coinsurance will not exceed any deductible, copayment or coinsurance applicable to an in-person consultation.

Treatment of Speech, Hearing and Language Disorders *(GR-9N 11-145-01 MA)*

The plan will pay for the diagnosis and treatment by individuals licensed as speech-language pathologists or audiologists for acute speech, hearing and language disorders, but only if the services are made for:

- Diagnostic services rendered to find out if, and to what extent, your ability to speak or hear is lost or impaired;
- Rehabilitative services rendered that are expected to restore or improve your ability to speak or hear.

The treatment of speech, hearing and language disorders benefit does ***not*** cover:

- Diagnostic or rehabilitative services rendered before you become eligible for coverage or after termination of coverage;
- Special education (including lessons in sign language) to instruct you if your ability to speak or hear is lost or impaired, to function without that ability.
- Hearing aids, hearing aid evaluation tests, and hearing aid batteries;
- Hearing exams required as a condition of employment;
- Diagnostic or rehabilitative services for treatment of speech, hearing, and language disorders:
  - that any school system, by law, must provide; or
  - as to speech therapy, to the extent such coverage is already provided for under Early Intervention Services and Home Health Care Services; or
- Any services unless they are provided in accordance with a specific treatment plan which:
  - details the treatment to be rendered and the frequency and duration of the treatment;
  - provides for ongoing services; and
  - is renewed only if such treatment is still necessary.

Early Intervention Services Expenses *(GR9N 11 020 03 MA)*

Covered expenses include early intervention services provided by early intervention specialists who are working in early intervention programs certified by the department of public health upon referral by the **Physician** for dependents from birth until thirty six (36) months of age.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Early Intervention *(GR-9N-S-11-025-04)*	xxx% after the calendar year **deductible**.	xxx% after the calendar year **deductible**.

Autism Spectrum Disorders *(GR-9N 11-171 04 MA)*
Definitions:
Applied behavior analysis: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism services provider: a person, entity or group that provides treatment of autism spectrum disorders.

Autism spectrum disorders: any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Board certified behavior analyst: a behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.
Diagnosis of autism spectrum disorders: medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has 1 of the autism spectrum disorders.

Treatment of **autism spectrum disorders**: includes the following care prescribed, provided or ordered for an individual diagnosed with 1 of the **autism spectrum disorders** by a licensed physician or a licensed psychologist who determines the care to be medically necessary: habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; and therapeutic care.

Covered expenses include charges made by a **physician** or **behavioral health provider** for services and supplies for the following . The services and supplies must be ordered by a **physician** or a **behavioral health provider.**

Coverage includes diagnosis and medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has an ASD.

Treatment includes the following medically necessary care prescribed, provided or ordered for an individual diagnosed with an ASD by a licensed physician or a licensed psychologist.

- Habilitative or Rehabilitative Care: Professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavioral analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual. Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including in the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

- Pharmacy Care: Medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the health plan for other medical conditions.

- Care from a Psychiatrist: Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

- Psychological Care: Direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

- Therapeutic Care: Services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

- Applied behavior analysis (ABA).

Limitations:
Unless specified above, not covered under this benefit are charges for:
- Educational services for behavioral disorders are listed as not covered in the Medical Plan Exclusions and Limitations section of the Policy.

Preventive Health Care Services *(GR-9N 11-225-01 MA)*

The plan covers preventive health care services even though they are not incurred in connection with an **injury** or **illness**. They are included only for a dependent child under 6 years of age.

Preventive health care services are services provided for a routine exam of the child. Included are:

- A review and written record of the child's complete medical history;
- Taking measurements and blood pressure;
- Developmental and behavioral assessment;
- Vision and hearing screening, including a newborn hearing screening test performed before the child is discharged from the **hospital** or **birthing center**;
- Lead poisoning screening;
- Other diagnostic screening tests including:
  - One series of hereditary and metabolic tests performed at birth; and
  - Urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.
- Immunizations for infectious disease; and
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered expenses will only include charges for preventive health care services performed at birth and at approximately each of the following ages:

2 months	18 months
4 months	2 years
6 months	3 years
9 months	4 years
12 months	5 years
15 months	

Not covered under this benefit are charges incurred for:

- Services which are covered to any extent under any other part of the plan;
- Services which are covered to any extent under any other group plan sponsored by your Employer;
- Services for diagnosis or treatment of a suspected or identified injury or illness;
- Services not performed by a **physician** or under their direct supervision;
- Medicines, drugs, appliances, equipment or supplies;
- Dental exams.

Routine Cancer Screenings *(GR-9N 11-005-01 MA)*

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 baseline mammogram, for covered females age 35 but less than 40;
- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap smear every 12 months.

Treatment of Infertility *(GR-9N 11-135 06 MA)*

Basic Infertility Expenses

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

To be an eligible covered female for benefits you must be covered under this *Booklet-Certificate* as an employee, or be a covered dependent, who is the subscriber's legal spouse or domestic partner, referred to as "your partner".

Even though not incurred for treatment of an **illness** or **injury**, **covered expenses** will include expenses incurred by an eligible covered female for **infertility** if all of the following tests are met:

- A condition that is a demonstrated cause of **infertility**, has been recognized and diagnosed as **infertility**, by a gynecologist, infertility specialist, or your **physician**, and it has been documented in your medical records.
- The procedures are done; while not confined in a hospital; or any other facility; as an inpatient.
- The **infertility** is not caused by voluntary sterilization of either one of the partners (without surgical reversal). This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this *Booklet-Certificate*.

Comprehensive Infertility Services Benefits

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an **infertility specialist** upon **precertification** by **Aetna**, subject to all the exclusions and limitations of this *Booklet-Certificate*:

- Ovulation induction with menotropins; and
- Artificial insemination and intrauterine insemination.

Advanced Reproductive Technology (ART) Benefits

Advanced Reproductive Technology is defined as:

- In vitro fertilization (IVF-EP);
- Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery

ART services are defined as:
ART services, products, and procedures that are **covered expenses** under this *Booklet-Certificate*.

Infertility Case Management is defined as a program administered by **Aetna** that consists of:

- Evaluation of medical records to determine whether **ART services** are **medically necessary**;
- Determination of whether **ART services** are covered benefits;
- Pre-authorization for ART services by an **ART Specialist** when **ART services** are **medically necessary** and are covered benefits; and
- Case management for the provision of **ART services** for an eligible covered person.

Eligibility for ART Benefits

To be eligible for **ART** benefits under this *Booklet-Certificate*, you must meet the requirements above and:

- You first exhaust the comprehensive infertility benefits. Coverage for **ART services** is available only if comprehensive **infertility** services do not result in a pregnancy in which a fetal heartbeat is detected.
- Be referred by your **physician** to the infertility case management unit;
- Be issued **precertification** for **ART services** by the infertility case management unit to an **ART specialist**.
- **ART services** are available only from the **ART specialists** for whom you have been issued a **precertification** by **Aetna's** infertility case management unit. Treatment received without pre-authorization will not be covered and you will be responsible for payment of all services..

Covered ART Benefits

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the *Exclusions and Limitations* section of the *Booklet-Certificate*:

- IVF-EP; GIFT; ZIFT; or cryopreserved embryo transfers;
- ICSI, assisted hatching or ovum microsurgery;
- Payment for charges associated with the care of an eligible covered person under this Plan who is participating in a donor IVF-EP program, including fertilization and culture;
- Charges associated with obtaining sperm, egg and/or inseminated egg procurement and processing and bank of sperm or inseminated eggs, for **ART**, when the spouse is also covered under this Booklet-Certificate; and
- Egg and/or inseminated egg procurement and processing bank sperm inseminated eggs for **ART** to the extent such costs are not covered by the donor's insurer.

Exclusions and Limitations

Unless otherwise specified above, the following charges will not be payable as **covered expenses** under this *Booklet-Certificate*:

- **ART services** for a female attempting to become pregnant who has <u>not</u> had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the **infertility** program;
- **ART services** for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal; unless that person can document that there has been a successful reversal of a sterilization procedure and has been unable to conceive or produce conception for a period of 1 year if the female is age 35 or younger, or during a period of 6 months if the female is over the age of 35;
- Reversal of sterilization surgery;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the gestational carrier. This exclusion does not apply to sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs to the extent such costs are not covered by the donor's insurer;
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits or related to the treatment of **infertility** that are not **medically necessary**;;
- Any services or supplies provided without **precertification** from **Aetna's** infertility case management unit;

- **Infertility** and **ART** Services that do not meet the **Medical Necessity** guidelines;
- Ovulation induction and intrauterine insemination services if you are not **infertile**;
- Services and supplies obtained without **precertification** from the **infertility** case management unit;
- If you have Prescription Drug Coverage that includes oral and self-injectable infertility drugs, then oral and self-injectable infertility drugs are excluded under your medical plan.

Coverage under this benefit will terminate immediately upon termination of coverage under this *Booklet-Certificate*, subject to group continuation coverage requirements under COBRA or state continuation laws.

Important Note
Treatment received without **precertification** will not be covered. You will be responsible for full payment of the services.

Refer to the Schedule of Benefits for details about the maximums that apply to **infertility** services. The **lifetime maximums** that apply to **infertility** services apply differently than other **lifetime maximums** under this Plan.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment *(GR-9N S11-55-01 MA)*		
Basic and Comprehensive Infertility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Advanced Reproductive Technology (ART) Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Diabetic Equipment, Supplies and Education *(GR-9N 11-135 02 MA)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- Insulin and Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets, including blood glucose monitoring strips, ketone strips;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training;
- Foot care to minimize the risk of infection;
- All lab tests and urinary profiles;
- Voice synthesizers and visual magnifying aids;
- Therapeutic/molded shoes and shoe inserts;
- Insulin pump supplies;
- Insulin pens; and
- Oral medications.

Physician Visits *(GR-9N 11-020-01 MA)*

Covered expenses also include:

- Diabetic Self-Management Education: Training designed to instruct a person in self-management of diabetes. It may also include training in self care or diet. Such charges must be made by:
  - a **physician**, nurse practitioner, clinical nurse specialist; or
  - a **pharmacy** or dietician who is legally qualified by the *Commonwealth of Massachusetts* to provide diabetic management education.
- Your diabetic equipment and self-management education services benefit does *not* cover:
  - a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
  - a general program not just for diabetics; or
  - a program made up of services not generally accepted as necessary for the management of diabetes.

Important Reminder
Certain procedures need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.

Hormone Replacement Therapy *(GR-9N 11-200-01 MA)*

The plan will pay for outpatient services and supplies related to your hormone replacement therapy for peri and post menopausal women on the same basis as any other **illness**.

Contraception Services *(GR-9N 11-005-01 MA)*

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Pregnancy Related Expenses *(GR-9N 11-100-01 MA)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, the plan will pay for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit be conducted by a registered nurse, **physician**, or certified nurse midwife; and provided that any subsequent home visits determined to be clinically necessary shall be provided by a licensed health care provider.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Treatment of Mental Disorders and Substance Abuse *(GR-9N 11-172 01 MA)*

Treatment of Mental Disorders *(GR-9N 11-172-06 MA)*

Covered expenses include chargers made for the treatment of **Biologically-Based Mental Disorders** and **Non-Biologically Based Mental Disorders** by **Behavioral Health Providers** under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness. This includes the same copayments, coinsurance or deductibles.

Benefits consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary and active and noncustodial treatment to take place in the least restrictive clinically appropriate setting..

In addition to the above, **covered expenses** also include charges made for:

- Rape Related Mental or Emotional Disorders - Coverage shall be provided for the diagnosis and treatment of rape related mental or emotional disorders if the **covered person** is a victim of a rape or victim of an assault with intent to commit rape under the same terms and conditions and which are no less extensive that coverage provided for any other type of health care for physical illness.

- Children and Adolescents under the age of 19 - Benefits shall be covered under the same terms and conditions and which are not less extensive than coverage provided for any other health care for physical illness, for children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care provider, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including but not limited to:

  (1) an inability to attend school as a result of such a disorder;
  (2) the need to hospitalize the child or adolescent as a result of such a disorder;
  (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

Coverage shall be continue to be provided to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.

- Covered expenses also include psychopharmacological services and neuropsychological assessment services.

DEFINITIONS:
BIOLOGICALLY BASED MENTAL DISORDERS
(1)schizophrenia; (2) schizoaffective disorder; (3) major depressive disorder; (4) bipolar disorder; (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder; (8) delirium and dementia; (9) affective disorders; 10) eating disorders; (11) post traumatic stress disorder; (12) substance abuse disorders; and (13) autism.

OUTPATIENT SERVICES
Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:

- Office Visits to a **physician (**such as a **psychiatrist)**, psychologist, social worker, or licensed professional counselor, as well as other health professionals (includes **telemedicine** consultation).
- Individual, group and family therapies for the treatment of mental disorders.
- Other outpatient **mental disorder** treatment such as:
    - Outpatient **detoxification**.
    - **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment.
    - Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program under the direction of a **physician**.
    - Ambulatory **detoxification** – Outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications.
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
        - You are homebound because of **illness** or **injury**.
        - Your **physician** orders them.
        - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home.
        - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
    - Mental health injectables
    - Treatment of withdrawal symptoms.
    - Substance use disorder injectables.
    - 23 hour observation.
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing

INTERMEDIATE SERVICES
- Acute and other residential treatment
- Crisis stabilization

INPATIENT SERVICES
may be provided in

- a general hospital licensed to provide such services,
- in a facility under the direction and supervision of the department of mental health
- private mental hospitals licensed by the department of mental health, and substance abuse facilities licensed by the department of public health.

LICENSED MENTAL HEALTH PROFESSIONAL

- a licensed physician who specializes in the practice of psychiatry,
- a licensed psychologist,
- a licensed independent clinical social worker,
- a licensed mental health counselor,
- a licensed nurse mental health clinical specialist,
- a licensed alcohol and drug counselor, or
- a licensed marriage and family therapist within the lawful scope of practice for such therapist.

Substance Abuse*(GR-9N 11-172-03 MA*

Covered expenses include charges made for the treatment of **substance abuse** by **behavioral health providers.** In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a **behavioral health provider;** and
- The program of therapy includes either:
  - A follow up program directed by a **behavioral health provider** on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or **substance abuse**.

Please refer to the *Schedule of Benefits* for any **substance abuse deductibles,** maximums, **coinsurance limits** or **maximum out-of-pocket limits** that may apply to your **substance abuse** benefits.

Inpatient Treatment

This Plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **hospital** as well as a facility under the direction and supervision of the department of mental health, in a private mental hospital, or in a substance abuse facility appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of **substance abuse**.
- "Medical complications" include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital** is covered only when the **hospital** does not have a separate treatment facility section.

Important Reminder
Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Intermediate Care Treatment

Covered Medical Expenses include, but are not limited to, Level III community-based detoxification, acute residential treatment, partial confinement treatment, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for **substance abuse** while not confined as a full-time inpatient in a **hospital**, as well as a facility under the direction and supervision of the department of mental health, or in a private mental hospital, or in a substance abuse facility. Outpatient treatment may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.

Important Reminders:

- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments**/**deductibles**, maximums, **coinsurance limits** or **maximum out-of-pocket limits** that may apply to your **substance abuse** benefits.

Behavioral Health Provider *(GR-9N 34-010-01 MA)*

A licensed facility, organization or **other health care** provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, **mental disorders** acting within the scope of the applicable license. This includes:

- **Hospitals**;
- Psychiatric **hospitals**;
- **Residential treatment facilities**;
- **Psychiatric physicians**;
- Psychologists;
- Social workers;
- Psychiatric nurses;
- Addictionologists;
- Substance abuse facility licensed by the department of mental health;
- Level III community-based detoxification; acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health;
- Mental health or substance abuse clinic licensed by the department of public health;
- A public community mental health center;
- Professional office or home-based services;
- Licensed independent clinical social worker;
- Licensed mental health counselor;
- Licensed nurse mental health clinical specialist; or
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

Mental Disorder *(GR-9N 34-065 04 MA)*

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist, a psychiatric social worker, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

Any one of the following conditions is a **mental disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.
- Paranoia and other psychotic disorders.
- Delirium and dementia.
- Affective disorders.
- Eating disorders.
- Post traumatic stress disorders.
- Substance Abuse.
- All other mental disorders not otherwise identified and which are described in the most recent edition of the diagnostic and statistical Manual of Mental Disorders (DSM).

Also included is any other mental condition which requires **Medically Necessary** treatment.

MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	xxx% per admission after Calendar Year **deductible**	xxx% per admission after Calendar Year **deductible**
Other than Room and Board	xxx% per admission after Calendar Year **deductible**	xxx% per admission after Calendar Year **deductible**
Physician Services	xxx% per admission after Calendar Year **deductible**	xxx% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	xxx per admission after Calendar Year **deductible**	xxx per admission after Calendar Year **deductible**
Outpatient Services	xxx per visit **copay** then the plan pays xxx No Calendar Year **deductible** applies	xxx per visit after the Calendar Year **deductible**

Prescription Drug *(GR-9N 34-080-01 MA)*

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- Drugs and medicines prescribed for the treatment of cancer or HIV/AIDS even if the off-label use of the drug has not been approved by the FDA for that indication. However, such drug for the treatment of such indication is in one of the standard reference compendia or in medical literature. The term "standard reference compendia" means the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information. The term "medical literature" means published scientific studies appearing in any peer-reviewed national professional journal.

Thirty-One Day Continuation *(GR-9N 31-015-01 MA)*

Coverage under this plan which terminates in accordance with the prior terms of this section will be continued for 31 more days, subject to the following.

- Termination is not due to discontinuance of the Group Contract, or failure to make any required contributions.
- This plan's benefits will be reduced by any other benefits of like kind for which the person becomes eligible.
- If this plan provides a medical expense benefits conversion privilege the following must be submitted to **Aetna** within the 31 day period of continuation:
  - Application for the personal policy; and
  - The premium.

This applies unless the person elects any other available continuation.

Continuation of Coverage for Your Former Spouse

If your health expense benefit coverage for your dependent spouse would terminate because of divorce or of separate support, you may continue any such coverage in force by continuing premium payments.

Coverage may be continued if the valid decree of dissolution of marriage states that you do not have to provide medical or dental coverage for your former spouse.

Coverage will be continued beyond the first to occur of:

- The date you are no longer covered under this Plan.
- The date dependent coverage is discontinued under this Plan for your Eligible Class.
- The end of the period for which required contributions have been made.
- The end of any period set forth in the valid decree of dissolution of marriage during which you are required to provide medical or dental coverage for your former spouse.
- The date you or your former spouse remarries. In the event of remarriage of the group plan member, the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family plan or issuance of an individual plan.

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

Continuation of Coverage: Employment Ceases

If your employment terminates due to involuntary lay-off, you may continue Health Expense Coverage (except Dental Expense Coverage) for you and your dependents for 39 weeks. You must request that your coverage continue within 31 days after it would cease due to involuntary lay-off.

Coverage will cease before the end of the 39 weeks on the first to occur of:

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

- The date Health Expense Coverage discontinues for employees of your former employer.
- The end of a period equal to the length of time you were last insured.

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

Continuation of Coverage: Plant Closing

If your employment terminated due to a plant closing or partial closing, you may continue Health Expense Coverage, except Dental Expense Coverage for you and your dependents for 90 days. You must request that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Coverage will cease before the end of the 90 days on the first of:

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

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

The following terms are defined by Massachusetts law:

- Plant closing.
- Partial closing.

Continuation of Coverage for Your Dependents After Your Death

If you die while covered under any part of this plan, any Health Expense Coverage then in force for your dependents will be continued if:

- Your coverage is not then being continued after your employment has stopped due to involuntary lay-off.
- Such coverage is requested within 31 days after your death.
- Premium payments are made for the coverage.

Your spouse's coverage will cease when your spouse remarries. Any dependent's coverage, including your spouse's, will end when any one of the following happens:

- The end of the 39 week period right after the date the dependent's coverage would otherwise cease.
- The end of a period equal to the length of time you were last covered.
- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for coverage under this plan or another group plan.
- Dependent coverage ceases under this plan.
- Any required contributions cease.

Continuation of Coverage for Your Child

The terms of this Continuation of Coverage apply only to your dependent child:

- who attains the limiting age for eligibility; and
- whose coverage under this Plan would otherwise terminate; and
- who is engaged in an ongoing treatment under this Plan, in accordance with a written treatment plan, for a mental, behavioral, or emotional disorder.

Such child's health expenses coverage, except dental expense coverage, may be continued, if:

- written request for such continuation is made within 31 days of the date coverage terminates; and
- that such request includes the following:
  - an agreement to pay up to 100% of the cost to the plan; and
  - evidence, satisfactory to **Aetna,** of the existence of such a mental, behavioral, or emotional disorder.

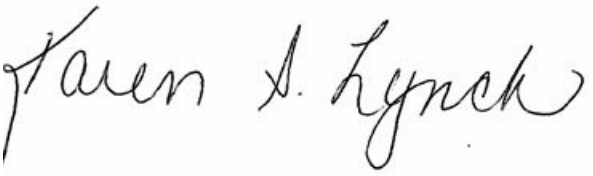
Premium payments must be made.

Coverage will cease on the first to occur of:

- the end of a 36 month period that starts on the date coverage would otherwise terminate (but not before the date a course of treatment for a non-biological mental disorder for children or adolescents under the age of 19, as specified in the treatment plan, is completed); or
- the date the child fails to provide the required proof that the course of treatment is still ongoing; or
- the date the child is eligible for similar benefits under any group plan; or
- the date the child becomes eligible for other coverage under the Group Policy; or
- the date the child fails to make any required contributions; or
- the date health expense coverage under this Plan discontinues for employees of your employer.

Aetna will have the right to require proof of the continuation of the course of treatment. **Aetna** also has the right to examine your child as often as needed while the course of treatment continues at its own expense. An exam will not be required more often than once each year.

If any coverage being continued ceases, the child may apply for a personal policy in accordance with the Conversion Privilege.



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

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

Routine Cancer Screenings *(GR-9N 11-006 06)*

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE); and
- Colonoscopies.

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; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Limitations
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:
- Services which are covered to any extent under any other part of this Plan.

Although not included in the guidelines recommended by the United States Preventive Services Task Force or the guidelines supported by the Health Resources and Services Administration, this Plan also covers one baseline mammogram for a woman age 35 but less than age 40.

Important Notes:
1. Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Preventive Care.
2. For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your **physician,** log onto the **Aetna** website www.aetna.com, or call Member Services at the number on the back of your ID card.

Any elective abortion coverage that may be provided by the plan has been removed from the Certificate of Coverage, unless the procedure is necessary to preserve the life of the mother.

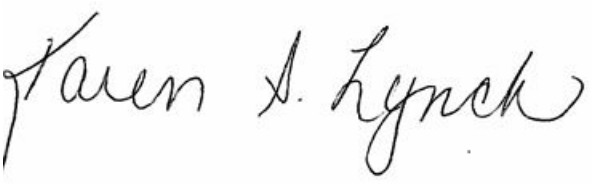
Autism Spectrum Disorders
Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Covered expenses include charges made by a **physician** or **behavioral health provider** for services and supplies for the diagnosis (including the autism diagnostic observation schedule or any other standardized diagnostic measure for Autism Spectrum Disorders that is approved by the Michigan Insurance Commissioner) and treatment of Autism Spectrum Disorder. The services and supplies must be ordered by a **physician** or a **behavioral health provider.**

Coverage also includes early intensive behavioral interventions such as Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that:
- Systematically change behavior; and
- Are responsible for the observable improvement in behavior.

Coverage for the treatment of Applied Behavioral Analysis for Autism Spectrum Disorders is subject to the maximum annual benefit amount, if any, shown on the *Schedule of Benefits*.

Limitations:
Unless specified above, not covered under this benefit are charges for:
- Educational services for behavioral disorders are listed as not covered in the *Medical Plan Exclusions and Limitations* section of the Policy.



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

Amendment: Michigan 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 Nevada. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

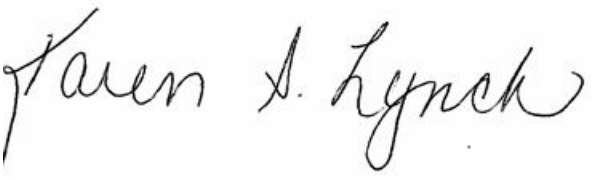
(GR-9N-S-01-01-GMP 01 NV)

The Department of Business and Industry, Division of Insurance of the State of Nevada provides a toll free telephone number which Nevada consumers may use for inquiries and complaints regarding health plans.

Toll Free Telephone Number: 1-888-872-3234

Hours of Operation: 8:00 AM to 5:00 PM Weekdays

Notice: The coverage provided by this certificate shall not deny a claim that involves an act of domestic violence, regardless of whether the insured contributed to any loss or injury.



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

Amendment: Nevada 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 Jersey. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Obtaining Coverage for Dependents *(GR-9N 29-010 03 NJ)*

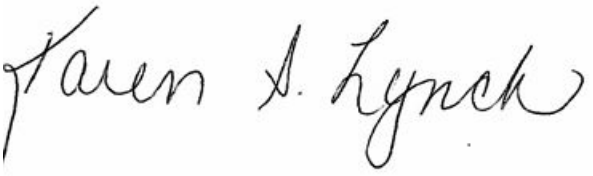
Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse/**civil union partner**; or
- Your domestic partner who meets the rules as defined by the State of New Jersey; and
- Your dependent children; and
- Dependent children of your domestic partner.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Civil Union Partner *(GR-9N 34-015 02 NJ)*

A person who has established a civil union as defined by New Jersey State Law. If applicable, any references under this Booklet-Certificate made to "marriage", "husband", "wife", "family", "immediate family", "dependent", "next of kin", "widow", "widower", "widowed" or another word which in a specific context denotes a marital or spousal relationship, the same shall include a **civil union partner**. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be treated as a **civil union partner** under New Jersey law.



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

Immunization Expenses

- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Immunizations for human papillomavirus (HPV) and the materials for administration of immunizations for covered females age 9 up to age 27; and
- Testing for Tuberculosis.

Anesthesia and Hospital Charges for Dental Surgery

Covered expenses include charges for **hospital** services and general anesthesia may by a **hospital** or **surgical center** for dental surgery for the following:

- Covered persons exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to product superior results;
- Covered persons for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
- Dependent children who are extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;
- Covered persons with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
- Other procedures for which **hospital** confinement or general anesthesia in a **hospital** or **surgical center** is **medically necessary**.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- 1baseline mammogram for covered females age 35 through 39;
- 1 mammogram every 2 years for covered females age 40 through 49;
- 1 mammogram every 12 months for covered females age 50 and over;
- cytologic screening, as recommended by your physician in accordance with national medical standards for covered females age 18 and over. Cytologic screening means a pap test and a pelvic exam for asymptomatic as well as systematic females;
- 1 gynecological exam every 12 months this includes a rectovaginal pelvic exam for women age 25 and over who are at risk of ovarian cancer
- 1 human papillomavirus (HPV) screening exam every 3 years for covered females age 30 and over;

The following tests are **covered expenses** if you are age 50 and older when recommended by your **physician**:

- 1 sigmoidoscopy every 5 years for persons at average risk; or
- 1 double contrast barium enema (DCBE) every 5 years for persons at average risk; or
- 1 colonoscopy every 10 years for persons at average risk for colorectal cancer

Contraception Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration (FDA);
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Children's Hearing Aid

Covered expenses for your covered dependent children include charges for one hearing aid for each hearing-impaired ear during any 36 consecutive month period. **Covered expenses** also include charges for fitting and dispensing services and molds necessary to maintain optimal fit.

Diabetic Equipment, Supplies and Education

Covered expenses include charges for the following services, supplies, equipment, and training for the treatment of insulin- and non-insulin-dependent diabetes and elevated blood glucose levels during pregnancy:

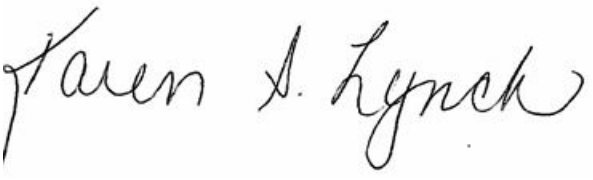
- Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets;
- Visual reading urine and ketone strips;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Foot care to minimize the risk of infection; and
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; which shall be limited to:
  - **medically necessary** visits upon the diagnosis of diabetes;
  - visits following a **physician** diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and
  - visits when re-education or refresher training is prescribed by a health care provider with prescribing authority; and
  - Medical nutrition therapy related to diabetes management.

Covered expenses include new or improved equipment, appliances, **prescription drugs** for the treatment of diabetes, insulin or supplies for the treatment of diabetes when approved by the food and drug administration.

Treatment of Jaw Joint Disorder

This Plan covers charges made by a **physician, hospital** or **surgery center** for the diagnosis; and surgical and non-surgical treatment of **jaw joint disorder**. A **jaw joint disorder** is defined as a painful condition:

- Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as myofacial pain dysfunction (MPD).



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

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

Obtaining Coverage for Dependents *(GR-9N 029-010 02 OR)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; or
- Your domestic partner who meets the rules outlined in the *Coverage for Domestic Partner* section below; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Domestic Partner *(GR-9N-29-010-01 CA)*

To be eligible for coverage, you and your domestic partner will need to:

- meet the requirements under Oregon law for entering into a domestic partnership; and
- jointly execute and register a Declaration of Domestic Partnership with the county clerk.

Coverage for Domestic Partner *(GR-9N-29-010-01 CA)*

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 intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past six 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 six months and intends to cohabitate and reside with you indefinitely.

- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
  - Common ownership of a motor vehicle;
  - Driver's license listing 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; or
  - Assignment of a durable property power of attorney or health care power of attorney.

Prosthetic and Orthotic Devices *(GR-9N-11-110-02 OR)*

Covered expenses include charges made for internal and external prosthetic and orthotic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic and orthotic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic and orthotic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes those in the most recent Medicare Fee Schedule.

The plan will not cover expenses and charges for, or expenses related to:

- Trusses, corsets, and other support items or
- any item listed in the *Exclusions* section.

Hearing Aids

Covered expenses, for a dependent child to age 18 or older if a full-time student in an accredited educational institution, includes charges for electronic hearing aids (monaural and binaural), installed in accordance with a **prescription** written by a physician or audiologist during a hearing exam.

This Plan covers charges for 1 hearing aid for each ear in any one period of 48 consecutive months up to the maximum benefit shown in your *Schedule of Benefits*.

Hearing Aids *(GR-9N-S-11-010-07)*	xxx% after Calendar Year **deductible**	xxx% after Calendar Year **deductible**
Maximum Benefit per 48 consecutive month period	$4,000	$4,000

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet-Certificate*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

Important Reminder
Refer to the *Schedule of Benefits* for details on any applicable **deductible**, **coinsurance** and maximum benefit limits.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Smoking Cessation

Covered expenses for a covered person who is 15 years of age or older include physician services, prescription drugs and over-the-counter medications prescribed by a physician for a tobacco use cessation program.

A tobacco use cessation program means a program recommended by a physician that follows the United States Public Health Services guidelines for tobacco use cessation. A tobacco use cessation program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

Tobacco Cessation		
Physician Services	Cost sharing is based upon the type of physician providing the service.	Cost sharing is based upon the type of physician providing the service.
Prescription Drugs and Over-the-Counter Medications	xxx% per prescription, medication or refill, after Calendar Year **deductible**	xxx per prescription, medication or refill, after Calendar Year **deductible**

The following exclusion has been removed:

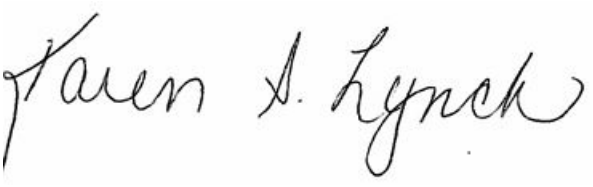
Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.

Smoking Cessation

Tobacco Cessation. For a covered person who is 15 years of age or older, the prescription drug plan covers prescription drugs and over-the-counter medications prescribed by a physician that are recommended by a physician and follow the United States Public Health Services guidelines for tobacco use cessation.

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to food.



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

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

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	TW Ventures Inc.
Group Policy No.:	GP-861495-C
Rider:	Ohio ET Medical
Issue Date:	August 3, 2020
Effective Date:	July 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Ohio. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Ohio, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Precertification must be obtained for opioid analgesics for the treatment of chronic pain except when a drug is prescribed for an individual who is:

- A hospice patient
- Diagnosed with a terminal condition
- A cancer patient

Precertification requests for opioid treatment will be treated as an expedited service in accordance with applicable state and federal law.

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

If you may be at risk for an adverse outcome or you have experienced an adverse outcome due to medication use, we can connect you with a nurse to navigate benefits and treatment plans. To talk to someone about treatment with opioids, or treatment for opioid addiction, call the Member Services number on your ID card.

Child Health Supervision Services *(GR-9N 11-005-01 OH)*

Covered expenses include charges for the periodic review of a child's physical and emotional status performed by a **physician** for a child from birth to age 9.

A periodic review is a review performed in accordance with the recommendations of the American Academy of Pediatrics and includes:

- A review and written record of the child's complete medical history.
- Taking measurements and blood pressure.
- Anticipatory guidance.
- Development and behavioral assessment.
- Hearing screening.
- Vision and lead toxicity screening and immunizations.
- One series of hereditary and metabolic tests performed at birth.
- Urinalysis and blood tests such as hematocrit and hemoglobin tests.
- Counseling and guidance of the child and the child's parents or guardians on the results of the physical exam.

Child Health Supervision Services are limited to charges incurred at birth and approximately each of the following ages:

One month	12 months	4 years
2 months	15 months	5 years
4 months	18 months	6 years
6 months	2 years	7 years
9 months	3 years	8 years

Child Health Supervision Services provided from birth to age 1 including hearing screening are covered up to the Birth to Age One Maximum.

Child Health Supervision Services thereafter are covered up to the Age One to Age Nine Calendar Year Maximum.

Hearing screenings are covered up to the Hearing Screening Maximum.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for Child Health Supervision Services.

Gatekeeper PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Child Health Supervision Services (From Birth to Age 9)	100% per exam No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**
Child Health Supervision Services		
Birth to Age One Maximum	$500	$500
Birth to Age One - Hearing Screening Maximum	$75	$75
Age One to Age Nine - Calendar Year Maximum	$150	$150

Screening Mammography and Cytologic Screening *(GR-9N 11-005-01 OH)*

Covered expenses include charges for screening mammography to detect the presence of breast cancer in adult women and cytologic screening for the presence of cervical cancer.

Mammography screenings are covered up to:

- 1 screening for a woman age 35 but under age 40;
- 1 screening every 2 years for a woman age 40 but under age 50 or 1 every year if a physician has determined that the woman has risk factors to breast cancer;
- 1 screening every year for a woman age 50 or older but under age 65.

Cytologic screenings are covered up to every 12 month consecutive period.

The most that the plan will pay for each mammography screening is the Mammography Screening Maximum.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings *(GR-9N S-11-15 01 OH)*		
Routine Mammography	100% per test No Calendar Year **deductible** applies.	60% per test after Calendar Year **deductible**
Maximum visits	▪ 1 visit for females age 35 through 39 ▪ 1 visit every year for females age 40 and over	▪ 1 visit for females age 35 through 39 ▪ 1 visit every year for females age 40 and over
Mammography Screening Services Maximum	In no event will the Mammography Screening Maximum exceed 130% of the Medicare reimbursement rate for screening mammography. (Payment shall be made in full to the Provider, Hospital or other Health Care Facility, excluding approved **deductibles** and **copays**)	In no event will the Mammography Screening Maximum exceed 130% of the Medicare reimbursement rate for screening mammography. (Payment shall be made in full to the Provider, Hospital or other Health Care Facility, excluding approved **deductibles** and **copays**)

Pregnancy Related Expenses *(GR-9N 11-100 01 OH)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include the charges for post discharge follow-up care for a mother and her newborn ordered and supervised by a **physician**. Services related to maternity follow-up care are covered whether such services are provided in a medical setting or in the home.

If the mother is discharged earlier than the minimum lengths of stay indicated above, all follow-up care received within 72 hours after discharge is covered without regard to medical necessity.

If the mother receives at least the minimum number of hours of inpatient care shown above, follow-up care that is not medically necessary will not be covered.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Off-Label Use *(GR-9N 13-005 01 OH)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, at **Aetna's** sole discretion, be subject to **precertification**, **step-therapy** or other **Aetna** requirements or limitations.

Continuing Coverage After You Terminate Employment *(GR-9N 31-015-01 OH)*

You have the option to continue your and your dependent's health care benefits for up to 6 months if coverage would otherwise end because your employment ends.

You are eligible for this continuation but only if you:

- have been covered under the group policy for 3 months before employment ended;
- are entitled to unemployment compensation benefits when employment ended;
- are not or do not become covered or eligible for coverage by Medicare; and
- are not or do not become covered or eligible for comparable benefits under any other group or individual plan.

Your employer will notify you of this option at the time your employment ends and the amount of the contribution required.

You must elect continuation and pay the required contribution to the employer no later than the earlier of:

- 31 days after the date your coverage would otherwise terminate;
- 10 days after the date your coverage would otherwise terminate, if notice is given before that date; or
- 10 days following the date coverage would otherwise terminate, if notice is given after that date.

Coverage under this continuation will end on the first to occur of:

- You cease to be eligible for this continuation as shown above;
- 6 months following the date coverage would otherwise terminate due to termination of employment;
- You fail to make the required contribution; or
- The group policy terminates.

Coordination Disputes *(GR-9N 33-015 01 OH)*

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686- 1526.

Continuing Coverage for Dependents After Your Death

If you should die while enrolled in this plan, your dependent's coverage will continue as long as:

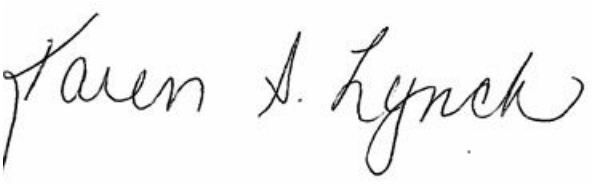
- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the *When Coverage Ends* section;
- A request is made for continued coverage within 31 days after your death; and
- Payment is made for the coverage.

Your dependent's coverage will end when the first of the following occurs:

- The end of the 12 month period following your death;
- He or she no longer meets the plan's definition of "dependent";
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent's coverage is being continued for your dependents, a child born after your death will also be covered.

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Medical Insurance Policy* for more information.



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

Amendment: Ohio Medical ET
Issue Date: August 3, 2020

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

Clinical Trial Expenses *(GR-9N-11-094-01 TN)*

This plan will pay for the **medically necessary** and routine patient care **physician** and facility charges incurred by a person who is enrolled in a Phase I, Phase II, Phase III or Phase IV Clinical Trial study. A "clinical trial" means a patient research study that is designed to evaluate a new drug, medical device, or service that falls within a Medicare benefit category and is not statutorily excluded from coverage. Such proposed treatment:

- must be intended to treat cancer;
- must have therapeutic intent; and
- must be recommended by the person's treating **physician** as having meaningful potential benefit to the person based upon at least two documents of medical and scientific evidence.

The clinical trial must meet the following criteria:

- It must involve a drug that is exempt under federal regulations from new drug application.
- It must be approved by centers or cooperative groups that are funded and sponsored by the National Institutes of Health, the Food and Drug Administration (FDA) in the form of an investigational new drug application, the Department of Defense, or the Department of Veterans Affairs.

Charges for **covered expenses** incurred by a person for:

- health care services for the appropriate monitoring of the person during the clinical trial; and
- the treatment;
- provided in the clinical trial; and
- that is a result of unintended medical complications caused by the treatment provided in the clinical trial;

are payable on the same basis as any illness or injury covered under this Plan.

Any care provided in the clinical trial must be for services that are considered **covered expenses** under this plan. They must be consistent with all of the terms and conditions of this plan including, but not limited to:

- **Aetna's** Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Covered expenses are subject to all of the terms; conditions; provisions; limitations; and exclusions of this plan including, but not limited to **precertification** and referral requirements.

Limitations
Unless specified above, the clinical trial benefit does ***not*** cover charges for:

- any drug, device, or service that is not approved by the FDA and that is associated with the clinical trial; and
- any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry; and
- costs of data collection and record-keeping that would not be required but for the clinical trial; and
- any expenses for the management of research;
- any expenses related to participation in the clinical trial, including travel, housing, and other expenses;
- any expenses incurred by a person accompanying the person; and
- any expenses related to determining eligibility for participation in the clinical trial; and
- services and supplies provided "free of charge" by the trial sponsor to the person.

Off-Label Use *(GR-9N-11-110-01 TN)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **Aetna's** sole discretion, be subject to **precertification, step-therapy** or other **Aetna** requirements or limitations.

Recovery of Overpayments *(GR-9N-32-015-01 TN)*

Health Coverage

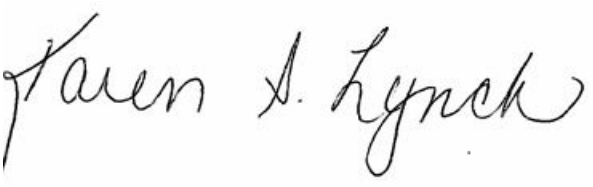
If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right will not apply more than 15 months as to you and 18 months as to a health care provider after the overpayment was made unless:

- the overpayment was made due to failure to provide complete information, fraud or material misstatements (on the part of you or the health care provider); or
- you or the health care provider has otherwise agreed to return the overpayment.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.



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

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

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	TW Ventures Inc.
Group Policy No.:	GP-861495-C
Rider:	Washington ET Medical
Issue Date:	June 19, 2019
Effective Date:	August 1, 2019

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Washington. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Washington, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Remember plan contributions are subject to change.

Your contributions may be reduced due to **Aetna's** failure to provide agreed upon service levels. Such service levels are guaranteed by **Aetna** and agreed to in writing by **Aetna** and your employer. See your employer for details.

You will need to enroll yourself and any eligible dependents within 30 days of your eligibility date. Otherwise, you or your eligible dependents will be considered a **late enrollee**. If you miss the enrollment period, you and your eligible dependents will not be able to participate in the plan until the next open enrollment period, unless you qualify under a Special Enrollment Period, as described below.

After the initial enrollment period, newborns, adopted children and children placed with you for adoption are automatically covered for 60 days after birth, adoption or placement for adoption. If the addition of your newborn or adopted child will increase your premiums, you will need to complete a change form and return it to your employer within the 60-day enrollment period to continue coverage for your child.

New Dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and

- You elect coverage for yourself and your dependent within 30 days of acquiring the dependent through marriage.
- You elect coverage for yourself and your dependent within 60 days of acquiring a dependent through birth, adoption or placement for adoption.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

If the special enrollment will result in additional premiums, you will need to report any new dependents by completing a change form, which is available from your policyholder. The form must be completed and returned to Aetna within 31 days of the change for the addition of a spouse, and 60 days for the addition of a dependent child, by birth, adoption, or placement with you for adoption. If you do not return the form within these timeframes, you will need to make the changes during the next open enrollment period unless you qualify for another special enrollment period.

Mammograms
- 1 mammogram every 12 months for covered females age 40 and over; or as recommended by your treating **health care provider.**

Neurodevelopmental Therapy
Occupational therapy, speech therapy and physical therapy delivered to covered dependents age six and under for the maintenance of the dependent's functioning in cases where significant deterioration in his or her condition would result without the service or to restore and improve function.

Home Health Care

Covered expenses include charges made by a **home health care agency** for home health care, when you have consented to home health care as an alternative to inpatient care and the care:

- Is given under a **home health care plan**;
- Is given to you in your home while you are **homebound**; and
- Is in lieu of a stay in a **hospital** or other inpatient facility.

Home health care expenses include charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N**.;
- Part-time or intermittent home health aid services provided in conjunction with and in direct support of care by an **R.N.** or an **L.P.N.**;
- Physical, occupational, and speech therapy;
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an **R.N.** or an **L.P.N.**; and
- Medical supplies, **durable medical equipment, prescription drugs** and lab services by or for a **home health care agency** to the extent they would have been covered under this plan if you had continued your **hospital stay**.

Benefits for home health care visits are payable up to the home health care maximum shown in the *Schedule of Benefits***.** Each visit by a nurse or therapist is one visit.

In figuring the home health care maximum visits, each visit of up to 4 hours is one (1) visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, covered medical expenses include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for home health care services does not include **custodial care**. The need for a caregiver to perform a non-skilled or **custodial care** service does not cause the service to become a **covered expense** under this plan. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled or **custodial care** needs.

Note:
Home short-term physical, speech, or occupational therapy is covered when home health care is provided in lieu of inpatient care.

Limitations
Unless expressly provided in the home health care benefit description above, the following are ***not*** **covered expenses:**

- Services or supplies that are not a part of the **home health care plan**;
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family;
- Services of a certified or licensed social worker;
- Transportation;
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present; and
- Services that are **custodial care**.

Important Reminders

- The plan does ***not*** cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.
- Home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.
- Refer to the *Schedule of Benefits* for details about home health care visit maximums.

Hospice Care

Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses
The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses
Covered expenses include charges made on an outpatient basis by a **hospice care agency** for:

- Part-time or intermittent nursing care by an **R.N.** or **L.P.N.**;
- Part-time or intermittent home health aide services to care for you in accordance with the approved treatment plan;
- Medical social services under the direction of a **physician** or **other health care provider**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy;
- Consultation or case management services by a **physician** or **other health care provider**;
- Medical supplies;
- **Prescription drugs**;
- Dietary counseling; and
- Psychological counseling; and
- Respite care that is continuous in the most appropriate setting for a maximum of 5 days per 3 month period of **Hospice Care**.

Covered expenses also include charges made by the providers below if they are not an employee of a **hospice care agency** and such agency retains responsibility for your care:

- A **physician** or other **health care provider** for a consultation or case management;
- A physical or occupational therapist; and
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care as set forth in the approved treatment plan;
  - Medical supplies;
  - **Prescription drugs**;
  - **Durable medical equipment (DME)** which would have been provided in an inpatient setting;
  - Psychological counseling; and
  - Dietary counseling.

Limitations

Unless specified above, charges for the following are not **covered expenses**:

- Daily **room and board** charges over the **semi-private room rate**;
- Bereavement counseling;
- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling (this includes estate planning and the drafting of a will); and
- Homemaker or caretaker services; these are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members, transportation, and maintenance of the house.

Important Reminders

- Refer to the *Schedule of Benefits* for details about **hospice care** maximums.

Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**

Acupuncture
The plan covers charges made for acupuncture services provided by a **health care provider**, within the scope of his or her license, if the service is performed:

- As a form of anesthesia in connection with covered surgery; or
- To treat an **illness**, **injury** or alleviate chronic pain.

Physician
A duly licensed member of a medical profession who:

- Has a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction within which he or she practices;
- Provides medical services which are within the scope of his or her license or certificate, and
- Is not any person who resides in your home; or who is a member of your family, or a member of your spouse's family or your domestic partner.

Continuation of Coverage During a Labor Dispute

If your coverage under this plan would cease because you cease work due to a strike, lockout or other labor dispute, you can arrange to continue your coverage during your absence from work. You may make the premium payments to your employer. Your employer will transmit the payments to **Aetna**. Call the Member Services toll free number on you ID card for information on the premium payment process. Coverage may continue for up to 6 months. At the end of 6 months you will be eligible for Conversion Coverage.

Continuation will cease when the first of these events occurs:

- You fail to make the required contributions;
- You go to work full time for another employer;
- The labor dispute ends; or
- The 6 month continuation period ends.

The monthly premium required by **Aetna** for each person's coverage will be the applicable effective rate in effect on the date you cease work. If the premium paid by your employer changes during the time you are continuing coverage under this provision, your premiums will change correspondingly.

Coordination of Benefits

Benefits Subject To This Provision: This coordination of benefits (COB) provision applies to **this plan** when you or your covered dependent has medical, dental, vision, or hearing coverage under more than one **plan.** "**Plan**" and "**this plan**" are defined herein. The order of benefit determination rules below determines which **plan** will pay as the **primary plan**. The **primary plan** pays first without regard to the possibility that another **plan** may cover some expenses. A **secondary plan** pays after the **primary plan** and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total **allowable expense**.

Definitions. When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means any health care expense for any **medically necessary** health care service or supply, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the **plans** covering the person. When a **plan** provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an **allowable expense** and a benefit paid. **This plan** limits coordination of health care services or expenses with those services or expenses that are covered under similar types of **plans,** (for example, Medical coverage is coordinated with another Medical **plan**). An expense or service that is not covered by any of the **plans** is not an **allowable expense**. This plan does not coordinate benefits for **prescription drugs**. The following are examples of expenses and services that are not **allowable expense**s:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an **allowable expense**. This does not apply if one of the **plans** provides coverage for a private room.
2. If a person is covered by 2 or more **plans** that compute their benefit payments on the basis of **UCR charges** or relative value schedule reimbursement or other similar reimbursement method, any amount in excess of the highest of the reimbursement amount for a specified benefit is not an **allowable expense**.
3. If a person is covered by 2 or more **plans** that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest negotiated charges is not an **allowable expense**.
4. If all plans covering a person are high deductible plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible plan's deductible is not an **allowable expense**, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

When a **plan** provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an **allowable expense** and a benefit paid.

Claim Determination Period. A Calendar Year.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation. In cases where a court decree awards more than half of the Calendar Year's residential time to one parent without the use of "custodial" terminology, the parent to whom the greater resident time is awarded is considered the **custodial parent**.

Plan. Any **plan** providing benefits or services by reason of medical, dental, vision or hearing care or treatment, which benefits or services are provided by one of the following:

- Group, individual or blanket disability insurance contracts, and group or individual contracts;
- Closed panel plans or other forms of group or individual coverage;
- The medical care components of long term care contracts, such as skilled nursing care; and
- Medicare or other governmental benefits as permitted by law.

Plan does not include:

- Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined in WAC 284-50-370;
- School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from school" basis;
- Benefits provided in long-term care insurance policies for non medical services;
- Medicare Supplement policies;

- A state plan under Medicaid;
- A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan'
- Benefits provided as part of a direct agreement with a direct patient-provider primary care practice' and
- Automobile insurance policies required by statute to provide medical benefits.

If the **plan** includes medical, dental, vision and hearing coverage, those coverages will be considered separate **plans**. For example, medical coverage will be coordinated with other medical **plans**, and dental coverage will be coordinated with other dental **plans**. This **plan** does not coordinate coverage for **prescription drugs**.

This plan is any part of the policy that provides benefits for health care expenses.

Primary plan/secondary plan. The order of benefit determination rules state whether **this plan** is a **primary plan** or **secondary plan** as to another **plan** covering the person.

- When **this plan** is a **primary plan**, its benefits are determined before those of the other **plan** and without considering the other **plan's** benefits. A **plan** is considered the **primary plan** if it either has no order of benefit determination rules, or if its rules differ from those permitted by Washington State regulations.
- When **this plan** is a **secondary plan**, its benefits are determined after those of the other **plan** and may be reduced because of the other **plan's** benefits. When coordinating benefits, any **secondary plans** must pay an amount which, together with the payment made by the primary plan, totals the higher of the **allowable expenses**. In no event will a **secondary plan** be required to pay an amount in excess of its maximum benefit plus accrued savings.
- When there are more than two **plans** covering the person, **this plan** may be a **primary plan** as to one or more other **plans**, and may be a **secondary plan** as to a different **plan** or **plans**.

Order of Benefit Determination
When two or more **plans** pay benefits, the rules for determining the order of payment are as follows:

- The **primary plan** pays or provides its benefits as if the **secondary plan** or **plans** did not exist.
- A **plan** that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the **plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.
- A **plan** may consider the benefits paid or provided by another **plan** in determining its benefits only when it is secondary to that other **plan**.

- The first of the following rules that describes which **plan** pays its benefits before another **plan** is the rule to use:
  1. Non-Dependent or Dependent. The **plan** that covers the person other than as a dependent, for example as an employee, covered person, subscriber or retiree is primary and the **plan** that covers the person as a dependent is **secondary**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **plan** covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **plans** is reversed so that the **plan** covering the person as an employee, covered person, subscriber or retiree is secondary and the other **plan** is primary.
  2. Child Covered Under More Than One **Plan**. The order of benefits when a child is covered by more than one **plan** is:
     A The **primary plan** is the **plan** of the parent whose birthday occurs earlier in each Calendar Year if:
        - The parents are married or living together whether or not married;
        - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the **plan** that covered either of the parents longer is primary.

     B If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the **plan** of that parent has actual knowledge of those terms, that **plan** is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the **primary plan**.
        - If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
          - The **plan** of the **custodial parent**;
          - The **plan** of the spouse of the **custodial parent**;
          - The **plan** of the non-**custodial parent**; and then
          - The **plan** of the spouse of the non-**custodial parent**.

     For a dependent child covered under more than one **plan** of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.
  3. Active Employee or Retired or Laid off Employee. The **plan** that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the **primary plan**. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the **secondary plan**. If the other **plan** does not have this rule, and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
  4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another **plan**, the **plan** covering the person as an employee, covered person, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other **plan** does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
  5. Longer or Shorter Length of Coverage. The **plan** that covered the person as an employee, covered person, or subscriber longer is primary. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The start of a new plan does not include a change in the amount or scope of a plan's benefits; a change in the entity that pays, provides, or administers the plan's benefits; or a change from one type of plan to another, such as from a single employer plan to a multiple employer plan.
  6. If the preceding rules do not determine the **primary plan**, the **allowable expense**s shall be shared equally between the **plans** meeting the definition of **plan** under this provision. In addition, **this plan** will not pay more than it would have paid had it been **primary** plus any accrued savings.

Effect on Benefits of This Plan
In determining the amount to be paid when this plan is secondary on a claim, the **secondary plan** will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any **allowable expense** under this plan that was unpaid by the **primary plan**. The amount will be reduced so that when combined with the amount paid by the **primary plan**, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total **allowable expense**.

In addition, a **secondary plan** will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of **this plan**, the amount normally reimbursed for covered benefits or expenses under **this plan** is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under **this plan** for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of **this plan** and another plan both agree that **this plan** determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more **closed panel plan**s COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans

When a **plan** is the **secondary plan**, it may reduce its benefits so that the total benefits paid or provided by all **plans** during a **claim determination period** do not exceed one hundred percent of the total **allowable expenses**. The **secondary plan** must calculate its savings by subtracting the amount that it paid as a **secondary plan** from the amount it would have paid had it been **primary**. These savings are recorded as a benefit reserve for the covered person and must be used by the **secondary plan** to pay any **allowable expenses** not otherwise paid, that are incurred by the covered person during the **claim determination period**. As each claim is submitted, the issuer of the **secondary plan** must:

- Determine its obligation under its **plan**;
- Determine whether a benefit reserve has been recorded for the covered person; and
- Determine whether there are any unpaid allowable expenses during that **claims determination period**.
- Use any amount that has accrued in the covered person's recorded benefit reserve to make payment so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period.

Multiple Coverage Under Aetna Plans
If a person is covered under **this plan** and another **Aetna** plan both as an employee and a dependent or as a dependent of 2 employees, the following will also apply:

- The person's coverage in each capacity under **this plan** and the other **Aetna** plan will be set up as a separate "**plan**".
- The order in which various **plans** will pay benefits will apply to the "**plans**" set up above and to all other **plans**.
- This provision will not apply more than once to figure the total benefits payable to the person for each claim under this **plan.**

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this **plan** and other **plans**. **Aetna** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment
Any payment made under another **plan** may include an amount which should have been paid under **this plan**. If so, **Aetna** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under **this plan**. **Aetna** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Claims, Appeals, Grievances, Independent Medical Review

Appeals Procedure

Definitions
Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit. Written notice of Adverse Benefit Determinations, including the reasons for the determination, will be provided to you and your provider according to the time frames given below. The notice will include information which will assist you in making an appeal if you wish to do so.

In Washington State, an **adverse benefit determination** is either:

- An "**adverse determination and noncertification**" which means a decision to deny, modify, reduce, or terminate payment for, coverage of, authorization of or provision of health care services or benefits including the admission to or continued stay in a facility"; or
- A decision that a service or benefit is not covered for other reasons including, but not limited to, member not eligible for coverage at time service is provided, benefit maximums under the plan have been reached, or the service or supply is not covered under the plan.

Such **adverse benefit determination** may be based on, among other things:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

Appeal: An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received. Refer to the *How the Plan Works, "Understanding Precertification"* section for additional information about when you or your **health care provider** must make **pre-service claims**.

Post-Service Claim: Any claim that is not a "**Pre-Service Claim**", "**Urgent Care Claim**" or a "**Concurrent Care Claim**".

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Jeopardize your life;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

You or **"the claimant"**. For purposes of this amendment "you" also means "you ***or*** your attending **health care provider** or the facility making the claim on your behalf".

Claim Determinations – Group Health Coverage

Urgent Care Claims

Aetna will make notification of an **urgent care** claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **health care provider** to provide **Aetna** with the information.

If the claimant fails to follow plan procedures for filing a claim, **Aetna** will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

If no additional information is required **Aetna** will make a claim determination as soon as possible but not later than 2 business days after the claim is made. **Aetna** will provide notification 2 calendar days after the **pre-service claim** determination is made. **Aetna** may determine that an extension is needed because **Aetna** needs additional information to make a claim determination**. Aetna** will notify you within 15 calendar days from receipt of a **pre-service claim** if additional information is needed. The notice of the extension shall specifically describe the required information. You will have 30 calendar days, from the date of the notice, to provide **Aetna** with the required information. **Aetna** will make the claim determination within 2 business days of receipt of all necessary information and will provide notification to the member and the attending **health care provider** or ordering provider or facility within 2 calendar days of the determination.

Post-service Claims

If all information necessary to evaluate a claim is provided when the **post service claim** is received, **Aetna** will make notification of a claim determination as soon as possible but not later than 30 calendar days after the **post-service claim** is made. **Aetna** may determine that we need additional information in order to make a claim determination, in which case we may request an extension. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. The notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information. **Aetna** will not retrospectively deny coverage for **precertified** care including **precertified prescription drugs**, if covered.

Concurrent Care Claim Extension

Following a request for **a concurrent care claim extension**, **Aetna** will make notification of a claim determination for **emergency** or **urgent care** as soon as possible but not later than 24 hours, with respect to **emergency** or **urgent care** provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. With respect to all other care, **Aetna** will make a determination within 14 days following a request for a concurrent care claim extension and will provide notification within one day of the determination.

Concurrent Care Claim Reduction or Termination
Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**, but in no event will the timeframe for the notification be longer than one day. If you choose to appeal **Aetna**'s determination, **Aetna** will continue to provide the previously approved course of treatment until the **appeal** is resolved, including Independent Medical Review if requested. If **Aetna**'s decision is affirmed then you will be responsible for the cost of the services provided after the termination date provided in the notification.

Notification of Adverse Determination and Noncertification
Notifications of claim determinations which include an **adverse determination and noncertification** will include the actual reasons for the determination, instructions for obtaining an appeal of the decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination. Notifications of an **adverse determination and noncertification** are provided to you and the treating **health care provider** or facility making the claim.

Complaints
If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must call or write Aetna Customer Service within 180 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a notification of receipt of your **complaint** within 5 days, and a written response within 14 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. If additional information is necessary to respond to your **complaint**, **Aetna** will notify you within the initial 14 day period and may extend the response time to 30 days from the date of receipt of the **complaint**. **Aetna** will not take longer than 30 days to respond to your **complaint** without your written permission. The notice of the decision will tell you what you need to do to request an External Review.

Appeals of Adverse Benefit Determinations
You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have 180 calendar days with respect to Group Health claims following the receipt of notice of an **adverse benefit determination** to request your **appeal**. Your **appeal** may be submitted orally or in writing and should include:

- Your name;
- Your policyholder's name;
- A copy of **Aetna**'s notice of an **adverse benefit determination**;
- Your reasons for making the **appeal**; and
- Any other information you would like to have considered.

Send in your **appeal** to Customer Service at the address shown on your ID card, or call in your **appeal** to Customer Service using the toll-free telephone number shown on your ID card.

Alternatively, you may send your **appeal** to the address shown on the notice of **adverse benefit determination**, or you may call in your **appeal** using the toll-free telephone number listed on such notice.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing written consent to **Aetna**.

An **appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel not involved in making the **adverse benefit determination**. You may request assistance making your **appeal** by calling the toll free customer service number listed on your ID card. **Aetna** will send you notification that your **appeal** has been received.

Appeal Response Times

Urgent care claims (may include concurrent care claim reduction or termination)

Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-service claims (may include concurrent care claim reduction or termination)
Aetna shall issue a decision within 14 calendar days of receipt of the request for an **appeal** unless additional information is necessary to complete review of the **appeal**. You will be notified within the initial 14 day period if additional information is necessary. **Aetna** will make a decision on the claim within 30 days of the receipt of the claim, unless we have your written consent to extend the **appeal** period. For **appeals** of claims decisions based on the determination that the requested treatment, service or supply is **experimental or investigational**, **Aetna** will issue a decision within 20 working days.

Post-Service Claims
Aetna shall issue a decision within 14 calendar days of receipt of the request for an **appeal** unless additional information is necessary to complete review of the **appeal**. You will be notified within the initial 14 day period if additional information is necessary. **Aetna** will make a decision on the claim within 30 days of the receipt of the claim, unless we have your written consent to extend the **appeal** period.

Exhaustion of Process

You are encouraged to exhaust the applicable process of the Appeal Procedure before you:

- contact the Office of the Insurance Commissioner to request an investigation of a **complaint** or **appeal**; or
- file a **complaint** or **appeal** with the Office of the Insurance Commissioner; or
- initiate any:
  - Litigation;
  - Arbitration; or
  - Administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

External Review Group Health Claims
If you do not agree with **Aetna's** decision of your **appeal**, or if **Aetna** takes longer than 30 days from the date of receipt of your **appeal** to reach a decision without your written consent, you or your provider may request an independent external review. An external review is a review by an External Review Organization, who assigns a reviewer with expertise in the problem or question involved to review your request and reach an independent decision.

The **appeal** denial letter you receive from **Aetna** will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to **Aetna** within 180 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

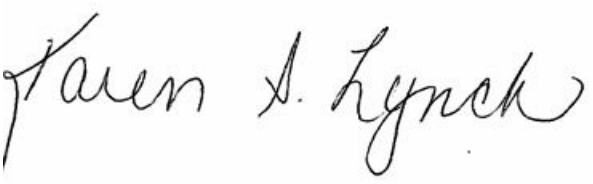
Aetna will contact the External Review Organization, according to the requirements of Washington Law, which will conduct the review of your claim and not later than the third business day after the date we receive your request for external review, will forward the required documents, including the material you sent to us to the External Review Organization. You may request a copy of the material we send, and we may request a copy of any additional material your or your treating provider send to the External Review Organization.

The External Review Organization will select an independent **physician** or contract specialist with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible

information that you send along with the Request for External Review Form, and will follow **Aetna**'s contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of **Aetna**'s receipt of your request form and all necessary information. A quicker review is possible if your **health care provider** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after **Aetna** receives the request.

Aetna will abide by the decision of the External Review Organization.

Aetna is responsible for the cost of sending the information that was used to make the initial determination and the claim determination, and any information from you or your provider to the External Review Organization and for the cost of the external review. You are responsible for the cost of compiling and sending documentation other than medical records that you wish to be reviewed by the External Review Organization to **Aetna**.



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